

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 8 1960

60-011728

Registration District No. 167 Primary Registration District No. 3040 Registrar's No. 61

STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <i>Livingston</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Livingston</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Chillicothe</i> | | Length of stay in 1b <i>3 Weeks</i> | c. CITY OR TOWN <i>Chole</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Susans Rest Home</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <i>✓</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <i>Hattie</i> Middle <i>L</i> Last <i>Hibler</i> | | | 4. DATE OF DEATH Month <i>April</i> Day <i>3</i> Year <i>1960</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>1/11/1873</i> | 9. AGE (last birthday) <i>87</i> | IF UNDER 1 YEAR Months <i>2</i> Days <i>22</i> Hours <i></i> Min. <i></i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | 11. BIRTHPLACE (City and state or country) <i>Trenton Missouri</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> |
| 13a. FATHER'S NAME <i>John Chrisman</i> | | 13b. MOTHER'S MAIDEN NAME <i>Hatterive Kelly</i> | | 14. NAME OF HUSBAND OR WIFE <i>John T. Hibler</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT Address <i>John D. Emanuel Chole</i> | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH <i>4 mos</i> <i>7 mos</i> |
| IMMEDIATE CAUSE (a) <i>Gangrene of left foot & leg</i> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <i>Thrombo-angitic obliterans of left popliteal artery.</i> | | |
| DUE TO (c) | | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Generalized arteriosclerosis</i> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour <i></i> a.m. <i></i> p.m. <i></i> | Month, Day, Year <i></i> | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |

21. I attended the deceased from *Feb 1959* to *April 3, 1960* and last saw her/him alive on *4-3-60*
Death occurred at *1:15 pm* on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>T. L. Milazzo</i> (Degree or title) <i>D.O.</i> | 22b. ADDRESS <i>Chillicothe mo</i> | 22c. DATE SIGNED <i>4-4-60</i> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE <i>4/5/1960</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Whealing Cemetery</i> | 23d. LOCATION (City, town, or county) (State) <i>Whealing MO</i> |
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| 24. FUNERAL DIRECTOR <i>E. J. Robertson</i> | ADDRESS <i>Funeral Home - Chole MO</i> | 25. DATE RECD. BY LOCAL REG. <i>4/15/60</i> | 26. REGISTRAR'S SIGNATURE <i>Francis B. Neal</i> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. M. Robertson

Licensed Embalmer No. 4388
P. O. Address Laredo, Tex.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.