

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-014275
STATE FILE NUMBER

FILED VS MAY 2 1960 042

Registration District No. **1000** Primary Registration District No. **494** Registrar's No.

1. PLACE OF DEATH a. COUNTY BUCHANAN				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY ANDREW					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. JOSEPH		Length of stay in 1b 10 days		c. CITY OR TOWN RFD # 1 SAVANNAH		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOSEPH HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3 miles Northwest		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First WARREN Middle GEE Last HUGHES				4. DATE OF DEATH Month April Day 25 Year 1960					
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-4-21	9. AGE (last birthday) 39	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mill operator			10b. KIND OF BUSINESS OR INDUSTRY feed company		11. BIRTHPLACE (City and state or country) Fairfax, Missouri		12. CITIZEN OF WHAT COUNTRY U S A		
13a. FATHER'S NAME Robert Hughes			13b. MOTHER'S MAIDEN NAME Grace Smith			14. NAME OF HUSBAND OR WIFE Winnie I. Hughes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes WW II			16. SOCIAL SECURITY NO. 493-18-9177		17. INFORMANT Address Mrs. Winnie I. Hughes, Savannah RFD # 1				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolic closure of right internal carotid artery							INTERVAL BETWEEN ONSET AND DEATH 12 hours		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Mural thrombus Neurothrombosis, left ventricle							7-10 days		
DUE TO (c) High anterolateral myocardial infarction							10 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year									
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 4/14/60 , to 4/25/60 and last saw her/him alive on 4/25/60 Death occurred at 9:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Type name and title) Bary G. Feller, M.D.				22b. ADDRESS Physicians & Surgeons Bldg St. Joseph, Missouri			22c. DATE SIGNED 4/25/60 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 4-25-60	23c. NAME OF CEMETERY OR CREMATORY Fillmore Cemetery		23d. LOCATION (City, town, or county) Fillmore, Missouri				
24. FUNERAL DIRECTOR BREIT & HAWKINS ADDRESS SAVANNAH			25. DATE RECD. BY LOCAL REG. April 27, 1960		26. REGISTRAR'S SIGNATURE Wm. Clark Goodell				

BY AFFIDAVIT OF **Attending Physician** **C. A. Potter, Jr., M.D.** MEDICAL CERTIFICATION

OCT 13 1960

AUG 5 1960

JUN 1 1960

STATEMENT BY LICENSED EMBALMER

MAY 5 1960

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 James B. Hawkins

Licensed Embalmer No. 4536

P.O. Address Savannah

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.