

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031757

FILED VS SEP 8 1960

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 338

STATE FILE NUMBER

|   |   |   |  |  |   |  |   |       |
|---|---|---|--|--|---|--|---|-------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Francois</b>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>St. Francois</b> |   |  |   |       |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>  |   | Length of stay in 1b <b>4 1/2 hrs.</b>  |  | c. CITY OR TOWN <b>Leadwood</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |       |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bonne Terre Hospital</b>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location) <b>Bank St.</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Thomas</b> Middle <b>Frank</b> Last <b>Hartman</b>  |   |   |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>31</b> Year <b>1960</b>   |   |  |   |       |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>WHITE</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>12-28-1878</b>   | 9. AGE (last birthday) <b>81 yrs.</b>                           | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.  |       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(retired) watchman</b>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>St. Joe Lead Co.</b>                            |  | 11. BIRTHPLACE (City and state or country) <b>Oak Hill, Mo.</b> |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>   |       |
| 13a. FATHER'S NAME <b>Fayette Hartman</b>   |   |   | 13b. MOTHER'S MAIDEN NAME <b>Sarah E. Lockhart</b>                                   |  |   | 14. NAME OF HUSBAND OR WIFE <b>Sallie Hartman</b>  |   |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>  |   |   | 16. SOCIAL SECURITY NO. <b>claim # 490-03-2752-A</b>                                 |  | 17. INFORMANT Address <b>Blanche Caviness, Leadwood, Mo.</b>    |  |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>  |   |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>                                       |       |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerotic cardio-vascular disease</b>  |   |   |  |  |   |  | DUE TO (c) <b>Not Known</b>   |       |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |       |
| 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<br>Hour Month, Day, Year<br>a.m. p.m.   |   |   |  |  |   |  |   |       |
| 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 <b>Jan 2 1960</b> to <b>Aug 31 1960</b> and last saw her/him alive on <b>Aug 31 1960</b><br>Death occurred at <b>5:15pm</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |  |   |  |   |       |
| 22a. SIGNATURE <b>John W Hunt, MD</b> (Degree or title)   |   |   |  | 22b. ADDRESS <b>Leadwood Mo</b>  |   |  | 22c. DATE SIGNED <b>9/1/60</b>  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |   | 23b. DATE <b>9-2-1960</b>   | 23c. NAME OF CEMETERY OR CRYPTORY <b>Leadwood Cemetery</b>                           |  |   | 23d. LOCATION (City, town, or county) <b>Leadwood, Missouri</b> (State)  |   |       |
| 24. FUNERAL DIRECTOR <b>Bert L. Boyer, Leadwood, Mo.</b> ADDRESS  |   |   | 25. DATE RECD. BY LOCAL REG. <b>Sept. 2, 1960</b>                                    |  | 26. REGISTRAR'S SIGNATURE <b>Esther Rulloff</b>                 |  |   |       |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 29 1960

**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 Bert L. Boyer  
Licensed Embalmer No. 3445  
P. O. Address Radwood?

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.