

11 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034503

FILED VS OCT 17 1960

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. _____ Registrar's No. 1031

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u>	
b. CITY: (If outside corporate limits, give TOWNSHIP only); OR TOWNSHIP <u>Republic</u>		c. CITY: OR TOWNSHIP <u>Republic,</u>	
c. FULL NAME OF (If NOT in hospital, give location); HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<u>Fred Alexander Hessee</u>			<u>October 10, 1960</u>		

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-1884</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Merchant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>	11. BIRTHPLACE (City and state or country) <u>Cassville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>J.B. Hessee</u>	13b. MOTHER'S MAIDEN NAME <u>Ida Abernathy</u>	14. NAME OF HUSBAND OR WIFE <u>Flora Ann Sullivan</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>489-24-8045</u>	17. INFORMANT <u>Maro Hessee</u>	Address <u>Republic, Mo.</u>
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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 <u>6 days</u>
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>		
DUE TO (b) <u>Arteriosclerosis</u>		
DUE TO (c) _____		

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ 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
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21. I attended the deceased from <u>September 1960</u> to <u>October 1960</u> and last saw ^{him} alive on <u>9 October 1960</u>	
Death occurred at <u>2:00</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>Karl Leidinger</u>	(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Republic, Mo</u>	22c. DATE SIGNED <u>10-11-1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-12-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Republic, Mo.</u>
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24. FUNERAL DIRECTOR <u>Cantrell F.H. Republic, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-14-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie B. Melton</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 William B. Cantrell

Licensed Embalmer No. 182

P. O. Address Republic

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.