

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED VS OCT 17 1960

-60-038938
STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 156

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Marceline</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Benton Rest Home</u>		Length of stay in lb. <u>3 wks</u>	d. STREET ADDRESS (If outside, give location) <u>15812 Lake</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W.</u> Last <u>Hasford</u>			4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>60</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-1884</u>		9. AGE (In years last birthday) <u>76</u> IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor Atts.F.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Linn, Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>James</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Power</u>	
14. NAME OF HUSBAND OR WIFE <u>Gertrude (dec)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Jo Anne King</u>		Address <u>Marceline, MO</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, left lung</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Arteriosclerotic Heart Disease</u>		<u>Undetermined</u>
	DUE TO (c) <u>Cerebral Vascular Accident</u> <u>443X</u>		<u>Approx 2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? 2. 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 <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>			

20d. INJURY OCCURRED WHILE AT <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 <u>Marceline, Mo</u>	COUNTY <u>MO</u>	STATE <u>MO</u>
21. I attended the deceased from <u>10/10/60</u> to <u>10/13/60</u> and last saw her alive on <u>10/10/60</u> Death occurred at <u>11:25 Am</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Stenmon A. Horner, M.D.</u>		22b. ADDRESS <u>121 N. Kansas, Marceline, Mo</u>		22c. DATE SIGNED <u>10/14/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>10-16-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Privat</u>	23d. LOCATION (City, town, or county) <u>Marceline, Mo</u>	(State) <u>MO</u>

24. FUNERAL DIRECTOR <u>James McLaughlin</u>	ADDRESS <u>Marceline, MO</u>	25. DATE RECD. BY LOCAL REG. <u>10-15-60</u>	26. REGISTRAR'S SIGNATURE <u>H. S. ...</u>
---	---------------------------------	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

doctor, coroner, etc. must use any standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

VS OCT 21 1960 SA

STATEMENT BY LICENSED EMBALMER

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

Student
Signature of Student Embalmer

Signed *Herald F. Wade*

Licensed Embalmer No. *4172*

P. O. Address *Brown*

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.