

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

4910

STATE FILE NUMBER 61-019103

AMENDED

Registration District No. 2 1961

Primary Registration District No.

Registrar's No.

DATE AMENDED

INSTEAD OF

ITEM NO.

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |  |   |  |   |  |  |   |  |                                    |  |       |  |
|---|--|---|--|---|--|--|---|--|------------------------------------|--|-------|--|
| 1. PLACE OF DEATH<br>a. <del>XXXXX</del> City of St. Louis  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Okla. b. COUNTY   |  |  |   |  |                                    |  |       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <i>St. Louis Mo</i>  |  | Length of stay in 1b<br><i>28 days</i>  |  | c. CITY OR TOWN<br><i>Oklahoma City</i>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |                                    |  |       |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><i>Finco Hosp</i>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                |   | d. STREET ADDRESS (If outside, give location)<br><i>1901 N.W. 28th St.</i> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>      |  |                                    |  |       |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Roy</i> Middle <i>E</i> Last <i>Hughes</i>  |  |   |  | 4. DATE OF DEATH<br>Month <i>5</i> Day <i>24</i> Year <i>61</i>   |  |  |   |  |                                    |  |       |  |
| 5. SEX<br><i>M</i>  |  | 6. COLOR OR RACE<br><i>W</i>  |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>8-13-1890</i>   |   | 9. AGE (last birthday)<br><i>70</i>                  |                                    | IF UNDER 1 YEAR<br>Months Days Hours Min.  |       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Railroad</i>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Railroad</i>  |  | 11. BIRTHPLACE (City and state or country)<br><i>Missouri</i>                        |   | 12. CITIZEN OF WHAT COUNTRY<br><i>U.S.A.</i>         |                                    |  |       |  |
| 13a. FATHER'S NAME<br><i>Benjamin Hughes</i>  |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><i>Nettie Lowe</i>   |  |  |   | 14. NAME OF HUSBAND OR WIFE<br><i>Frances</i>        |                                    |  |       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>NO</i>   |  |   |  | 16. SOCIAL SECURITY NO.<br><i>none</i>  |  | 17. INFORMANT<br>Address <i>1901 N.W. 28th Oklahoma City, Okla.</i>                  |   |  |                                    |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |  |   |  |                                    | INTERVAL BETWEEN ONSET AND DEATH   |       |  |
| IMMEDIATE CAUSE (a) <i>Occlusion of coronary artery</i>   |  |   |  |   |  |  |   |  |                                    | <i>10 PM</i>   |       |  |
| DUE TO (b) <i>Diarrhoeal heart disease</i>  |  |   |  |   |  |  |   |  |                                    | <i>5 PM</i>  |       |  |
| DUE TO (c) <i>420.0</i>   |  |   |  |   |  |  |   |  |                                    |  |       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><i>Cerebral hemorrhage; Carcinoma of liver</i>   |  |   |  |   |  |  |   |  |                                    | 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?<br>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 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 |  |
| 21. I attended the deceased from <i>4-27-61</i> to <i>5-24-61</i> and last saw him alive on <i>5-24-61</i><br>Death occurred at <i>7:55</i> <i>A</i> m on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |  |   |  |                                    |  |       |  |
| 22a. SIGNATURE<br><i>Wm F. Schuman, M.D.</i> (Degree or title)  |  |   |  |   |  | 22b. ADDRESS<br><i>H161 Sinden</i>   |   |  | 22c. DATE SIGNED<br><i>5/24/61</i> |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Removal</i>   |  | 23b. DATE<br><i>5-25-61</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION (City, town, or county) (State)<br><i>Oklahoma City, Oklahoma</i> |  |                                    |  |       |  |
| 24. FUNERAL DIRECTOR<br><i>Thomas Kutis 2906 Gravois Ave.</i> ADDRESS   |  |   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><i>MAY 24 1961</i>                                   |   | 26. REGISTRAR'S SIGNATURE<br><i>Earl Smith, M.D.</i> |                                    |  |       |  |

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

*James C. Will*

Licensed Embalmer No.

*4347*

P. O. Address

*2906 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.