

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024136

STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 767

ED AUG 7 1961

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| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY Buchanan | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | a. STATE Missouri b. COUNTY Buchanan | c. CITY OR TOWN St. Joseph |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 1018 North 9th | | Length of stay in 1b 30 Yrs | d. STREET ADDRESS (If outside, give location) 1018 North 9th |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|-------------------------------------|--------------|--------------|-------------|------------------|------------|--------|-----------|
| 3. NAME OF DECEASED (Type or print) | First HARLAN | Middle BURLE | Last HUGHES | 4. DATE OF DEATH | Month July | Day 29 | Year 1961 |
|-------------------------------------|--------------|--------------|-------------|------------------|------------|--------|-----------|

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|-------------|------------------------|--|---------------------------|---------------------------|------------------------|--------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 7-1-1900 | 9. AGE (last birthday) 61 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Cab Driver | 10b. KIND OF BUSINESS OR INDUSTRY Cab Co. | 11. BIRTHPLACE (City and state or country) Wilcox, Mo. | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME George Hughes | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Winona |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | 17. INFORMANT Leon Melkowski | Address St. Joseph, Mo. |
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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 |
| IMMEDIATE CAUSE (a) | <i>Coronary occlusion</i> | <i>noted</i> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <i>arteriosclerotic heart disease</i> | <i>2 yrs</i> |
| | DUE TO (c) | |

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| 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 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.) |
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|---|--|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY Hour 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>7-29-61</u> to <u>7-29-61</u> and last saw him alive on <u>7-29-61</u> Death occurred at <u>1:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <i>Clement Joseph</i> (Degree or title) | 22b. ADDRESS <i>St. Joseph, Mo</i> | 22c. DATE SIGNED <u>7-31-61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Aug. 1, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | 23d. LOCATION (City, town, or county) St. Joseph Missouri |
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| 24. FUNERAL DIRECTOR H.O. Sidempfen & Son | ADDRESS St. Joseph Mo | 25. DATE RECD. BY LOCAL REG. July 31, 1961 | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell |
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
INSTEAD OF
DOCUMENT
BY AFFIDAVIT OF
SHOULD READ
ITEM NO.

C.C. DuMont Medical Certification

SEP 26 1961

Dr. J. J. J. J.

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 Robert H. J. J.

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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.