

# CERTIFICATE OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033528

CERTIFICATE OF HEALTH AND WELFARE

Registration District No. 385 Primary Registration District No. 3038 Registrar's No. 30

STATE FILE NUMBER

<p><b>1. PLACE OF DEATH</b> a. COUNTY <u>Linn</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u> Length of stay in 1b <u>5 mos.</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Doctor's Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u></p> <p>c. CITY OR TOWN <u>Linneus</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>					
<p><b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CHARLES S. HOTALING</u></p>			<p><b>4. DATE OF DEATH</b> Month Day Year <u>August 10 1961</u></p>				
<p><b>5. SEX</b> <u>Male</u></p>	<p><b>6. COLOR OR RACE</b> <u>White</u></p>	<p><b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> <u>Widowed</u> <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>10-28-79</u></p>	<p><b>9. AGE (last birthday)</b> <u>81</u></p>	<p><b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HR</b> Hours Min.</p>		
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Abstracter - ret.</u></p>		<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Abstract Co.</u></p>		<p><b>11. BIRTHPLACE</b> (City and state or country) <u>Grant City, Missouri</u></p>		<p><b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u></p>	
<p><b>13a. FATHER'S NAME</b> <u>George Hotaling</u></p>			<p><b>13b. MOTHER'S MAIDEN NAME</b> <u>Mildred Robinson</u></p>		<p><b>14. NAME OF HUSBAND OR WIFE</b> <u>Jessie Hotaling</u></p>		
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>			<p><b>16. SOCIAL SECURITY NO.</b></p>		<p><b>17. INFORMANT</b> Address <u>Walter Hotaling, Linneus, Missouri</u></p>		
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Circulatory Collaspe</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>DUE TO (b) <u>Acute cerebral accident</u></p> <p>DUE TO (c) <u>Advanced age and generalized debility</u></p>						<p><b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 hr.</u></p> <p><u>31 hrs.</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Patient hospitalized for several months.</u></p>					<p>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</p>		
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p>	<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>					
<p><b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year</p>		<p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>					
<p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>20f. CITY, TOWN, OR LOCATION</b></p>		<p><b>COUNTY</b> <b>STATE</b></p>			
<p><b>21.</b> I attended the deceased from <u>March 19, 1961</u> to <u>August 10, 1961</u> and last saw her/him alive on <u>August 10, 1961</u> Death occurred at <u>11:00</u> <sup>a</sup> on the date stated above, and to the best of my knowledge, from the causes stated.</p>							
<p><b>22a. SIGNATURE</b> (Degree or title) <i>John St. Whitely</i></p>				<p><b>22b. ADDRESS</b> <u>Brookfield, Missouri</u></p>		<p><b>22c. DATE SIGNED</b> <u>8/12/61</u></p>	
<p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u></p>		<p><b>23b. DATE</b> <u>8-12-61</u></p>	<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>IOOF Cemetery</u></p>		<p><b>23d. LOCATION</b> (City, town, or county) (State) <u>Linneus, Missouri</u></p>		
<p><b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Wright Funeral Home, Linneus, Missouri</u></p>			<p><b>25. DATE RECD. BY LOCAL REG.</b> <u>8-12-61</u></p>		<p><b>26. REGISTRAR'S SIGNATURE</b> <i>Rene Watson</i></p>		

DATE AND TIME OF DEATH

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.