

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035538

STATE FILE NUMBER

AMENDED

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 25

FILED SEP 26 1961

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

| | | | | | | | |
|---|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Saline</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Boone</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Slater</u> | | Length of stay in 1b <u>2 months</u> | | c. CITY OR TOWN <u>Sturgeon</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>324 Carlisle</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Ellston</u> Middle <u>Carlton</u> Last <u>Hatton</u> | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1961</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</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>11/14/91</u> | 9. AGE (last birthday) <u>69</u> | IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>George Hatton</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Amanda Kelly</u> | | 14. NAME OF HUSBAND OR WIFE <u>Ida Hatton</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> | | | | 17. INFORMANT Address <u>John W. Harvey Ottumwa, Ia.</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>Carcinoma of Stomach</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4-6 weeks</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | DUE TO (b) | | DUE TO (c) | | |
| 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 | | |
| 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.) | | | |
| 20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> | | Month, Day, Year <u></u> | | | | | |
| 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 <u>August 24, 1961</u> to <u>Sept. 12, 1961</u> and last saw ^{her} him alive on <u>Sept 12, 1961</u> Death occurred at <u>11:45 a.m.</u> <u>7A.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>J. M. [Signature]</u> | | | | 22b. ADDRESS <u>312 1/2 N Main St Slater Mo</u> | | 22c. DATE SIGNED <u>9-23-61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>9/24/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sturgeon</u> | | 23d. LOCATION (City, town, or county) <u>Sturgeon, Mo</u> | | 23e. (State) <u></u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Doc G. Meador, Sturgeon, Missouri</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>9-23-61</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs. Raymond Braine</u> | |

JUL 3 1962

JAN 9 1962

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 George F. Hayes, Jr.

Licensed Embalmer No. 4630

P. O. Address Slater, 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.