

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-035631
STATE FILE NUMBER

AMENDED

Registration District No. 353 Primary Registration District No. 6196 Registrar's No. 16

FILED SEP 26 1961

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Licking</u>		c. CITY OR TOWN <u>Licking</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>Licking</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alta</u> Middle <u>Hallenbeck</u> Last <u>Hallenbeck</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>11</u> Year <u>1961</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>12-15-1882</u>
9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>78</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (City and state or country) <u>Texas, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Sam Potter</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Trusty</u>		14. NAME OF HUSBAND OR WIFE <u>✓</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. <u>✓</u>	
17. INFORMANT <u>Mar Paul West</u>		Address <u>Licking, 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>Cardiac & pulmonary arrest</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>hypertensive heart disease with</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiovascular renal syndrome</u>			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>3:45</u> a.m. <u>PM</u> Month, Day, Year <u>Sept 10, 1961</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>1954</u> to <u>1961</u> and last saw her alive on <u>Sept 10, 1961</u> Death occurred at <u>3:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>B. J. Myers D.O.</u> (Degree or title)		22b. ADDRESS <u>Licking, Mo.</u>	22c. DATE SIGNED <u>9-12-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-13-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Central Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Texas, Mo.</u>
24. FUNERAL DIRECTOR <u>Smith Ferguson</u> ADDRESS <u>Licking, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Sept. 18, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Elvora E. Hesse</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 29 1961

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 Hubert E. Ferguson

Licensed Embalmer No. 3945

P. O. Address Locking M.

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.