

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037564

AMENDED

Registration District No. 382Primary Registration District No. 5655Registrar's No. 99

STATE FILE NUMBER

FILED NOV 2 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY LAWRENCE		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MT. VERNON		Length of stay in 1b 25 days		c. CITY OR TOWN SPRINGFIELD	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MO. STATE SAN.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1015 E WALNUT		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First RAYBURN		Middle BEESON		Last HASTINGS		Month Day Year OCT 21 61	
5. SEX MALE	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-22-09	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PUBLIC HEALTH EDUCATOR		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC HEALTH		11. BIRTHPLACE (City and state or country) ATKINS, ARKANSAS		12. CITIZEN OF WHAT COUNTRY US	
13a. FATHER'S NAME LAWRENCE LAFAYETTE HASTINGS			13b. MOTHER'S MAIDEN NAME FANNIE MAY BEESON		14. NAME OF HUSBAND OR WIFE MARY HASTINGS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servit) NO				17. INFORMANT Address RAYBURN HASTINGS - SPRINGFIELD MO.			
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) CARCINOMA OF LUNG WITH METASTASIS							
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"/> N <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 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 9-26-61 to 10-21-61 and last saw him alive on 10-21-61				Death occurred at MO. STATE SAN on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) R. Vernon Langeluth M.D.				22b. ADDRESS Mo. State San.		22c. DATE SIGNED 10/21/61 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10-21-61	23c. NAME OF CEMETERY OR CREMATORY Crown Hill Cem.		23d. LOCATION (City, town, or county) Excelsior Springs Mo.			
24. FUNERAL DIRECTOR HOPE Funeral Home		ADDRESS Springfield MO		25. DATE RECD. BY LOCAL REG. 10-25-61		26. REGISTRAR'S SIGNATURE Loy Wynne	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

NOV 3 1961

NOV 2 AON SA

NOV 7 1961
SA
NOV 7 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 N. H. Forester

Licensed Embalmer No. 2201

P. O. Address W. H. Union

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.