

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-000192

STATE FILE NUMBER

AMENDED

Registration District No. 032 Primary Registration District No. \_\_\_\_\_ Registrar's No. 14

FILED FEB 13 1962

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BOBBINGER</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>LUTESVILLE</u>                  |  | Length of stay in 1b<br><u>2 YRS. 2 MOS.</u>   | c. CITY OR TOWN <u>CHAFFEE</u>                         |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>BOND NURSING HOME</u> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br>_____ |
|   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |

|   |   |
|---|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>MARY</u> Middle <u>EBBEN</u> Last <u>HALE</u> | 4. DATE OF DEATH<br>Month <u>FEB.</u> Day <u>1</u> Year <u>1962</u> |
|---|---|

|                      |                               |   |                                     |                                  |  |  |
|----------------------|-------------------------------|---|-------------------------------------|----------------------------------|--|--|
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEB. 5 1879</u> | 9. AGE (last birthday) <u>82</u> | IF UNDER 1 YEAR<br>Months <u>11</u> Days <u>26</u> | IF UNDER 24 HR<br>Hours _____ Min. _____ |
|----------------------|-------------------------------|---|-------------------------------------|----------------------------------|--|--|

|  |  |  |  |
|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSE WIFE</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br>_____ | 11. BIRTHPLACE (City and state or country)<br><u>JACKSON, MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u> |
|--|--|--|--|

|  |  |   |
|--|--|---|
| 13a. FATHER'S NAME<br><u>William W. Taylor</u> | 13b. MOTHER'S MAIDEN NAME<br><u>REBECCA E. SLACK</u> | 14. NAME OF HUSBAND OR WIFE<br><u>JESSE H. HALE</u> |
|--|--|---|

|   |                                  |  |               |
|---|----------------------------------|--|---------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u> | 16. SOCIAL SECURITY NO.<br>_____ | 17. INFORMANT<br><u>JOHN K. HALE - CAPE GIRARDEAU, Mo.</u> | Address _____ |
|---|----------------------------------|--|---------------|

|  |  |                                  |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:         |  | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>  |  |                                  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Central Thrombosis</u>     |                                  |
|  | DUE TO (c) <u>Cardiovascular disease</u> |                                  |

|   |  |
|---|--|
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|---|--|

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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.) |
|---|---|--|

|   |                        |
|---|------------------------|
| 20c. TIME OF INJURY<br>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 4/6/60 to 2/1/62 and last saw her alive on 2/1/62  
Death occurred at 4:20 PM on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                   |                                      |                                   |
|---|-------------------|--------------------------------------|-----------------------------------|
| 22a. SIGNATURE<br><u>John J. Myers D.D.</u> | (Degree or title) | 22b. ADDRESS<br><u>Lutesville Mo</u> | 22c. DATE SIGNED<br><u>2/6/62</u> |
|---|-------------------|--------------------------------------|-----------------------------------|

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> | 23b. DATE<br><u>FEB. 4, 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Old City Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>JACKSON Missouri</u> |
|--|----------------------------------|--|--|

|   |         |   |   |
|---|---------|---|---|
| 24. FUNERAL DIRECTOR<br><u>Bisplinghoff Funeral Home - Chaffee, Mo.</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><u>2/8/62</u> | 26. REGISTRAR'S SIGNATURE<br><u>Mrs Buford Crader</u> |
|---|---------|---|---|

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

FEB 19 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 Jack T. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee, Md.

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.