

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002704

STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 29

FILED JAN 26 1962

1. PLACE OF DEATH a. COUNTY <b>MARION</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>PIKE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HANNIBAL</b>		Length of stay in 1b <b>2 HOURS</b>	c. CITY OR TOWN <b>FRANKFORD</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LEVERING</b>		Inside Limits Yes <input checked="" 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 <b>OLIVE</b> Middle <b>HADEN</b> Last	4. DATE OF DEATH Month <b>JAN.</b> Day <b>19</b> Year <b>1962</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 16 1879</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>ROLLS Co. MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>ABNER HADEN</b>	13b. MOTHER'S MAIDEN NAME <b>EMMA WEBB</b>	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT Address <b>Miss Callie Haden Frankford Mo.</b>
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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 <b>2 wks</b>
IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Auricular Fibrillation &amp; embolic from <sup>embolic from</sup> Thrombi Intraural</b>	
DUE TO (c) <b>Chronic Myocardial Degeneration</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Complete Post-Prandial Cramps &amp; <sup>Cerebrotic</sup> Intoxication</b>	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
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19. WAS AUTOPSY PERFORMED? 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
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21. I attended the deceased from <b>May 19 1967</b> to <b>Jan 19 1962</b> and last saw her alive on <b>that date 12 AM</b> Death occurred at <b>7 12:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Deceased or informant) <b>Ralph H. Hayden D.O.</b>	22b. ADDRESS <b>519 W. Main Bowling Green, Mo.</b>	22c. DATE SIGNED <b>Jan 22 1962</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan 22 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Barbley Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>New London Missouri</b>
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24. FUNERAL DIRECTOR <b>Megaron Funeral Home Frankford Mo.</b>	25. DATE RECEIVED BY LOCAL REG. <b>Jan. 22, 1962</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E.M. Lusche by Callie Haden</b>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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 Joe J. Fields Megawon

Licensed Embalmer No. 4092

P. O. Address Franklin 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.