

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007648

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 106

AMENDED

FILED MAR 14 1962

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Iron	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Length of stay in 1b 1Y;7M;16das.	c. CITY OR TOWN Des Arc Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital No. 4		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) State Hospital No. 4 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EARL Middle TOBIAS Last HALEY			4. DATE OF DEATH Month March Day 2 Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1889	9. AGE (last birthday) 76	IF UNDER 1 YEAR IF UNDER 24 HR Months 3 Days 19 Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (City and state or country) West Plains, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Basil Hall Haley		13b. MOTHER'S MAIDEN NAME Lucinda Emiline Key		14. NAME OF HUSBAND OR WIFE Maude Haley (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Records, State Hosp. No. 4, Farmington, Mo. Address _____		

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) Metastatic carcinoma of the abdominal viscera		Abt. 4 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of the rectum (inoperable)	Abt. 1 year.
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Schizophrenic reaction, Chronic undifferentiated type.		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.)
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 **Dec. 14, 1961** to **March 2, 1962** and last saw ^{him} him alive on **March 2, 1962**
Death occurred at **3:15 P.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. L. Brenner, M.D.</i> (Degree or title)	22b. ADDRESS State Hospital No. 4, Farmington, Missouri	22c. DATE SIGNED 3-3-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 5, 1962	23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery	23d. LOCATION (City, town, or county) (State) Des Arc, Missouri
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24. FUNERAL DIRECTOR Hovell Funeral Home, Ironton, Missouri	ADDRESS _____	25. DATE RECD. BY LOCAL REG. March 3, 1962	26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

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 _____

W. Cozeman

Licensed Embalmer No. 4089

P. O. Address Levyton

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.