

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019677

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 237 Primary Registration District No. 4353 Registrar's No. 6

FILED MAY 29 1962

VS 300
Rev. 4/59

1 0720

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lideon</u>		c. CITY OR TOWN <u>Lideon</u>	
Length of stay in 1b <u>18 yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>None</u>		d. STREET ADDRESS (If outside, give location) <u>In Lideon</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE JANE HUTSON</u>			4. DATE OF DEATH Month Day Year <u>5 11 1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>6-12-1877</u>
9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Boone Co. Ky</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>W.A. Moore</u>	
13b. MOTHER'S MAIDEN NAME <u>Mathew Smith</u>		14. NAME OF HUSBAND OR WIFE <u>Woodrow Hutson Sr.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marian Hartfield, Mayfield Ky</u>		Address	
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>metastatic cancer.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mm hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma Coecum.</u>			<u>15 months.</u>
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"/> 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 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 <u>2-14-56</u> to <u>5-8-62</u> and last saw <u>her</u> alive on <u>5-8-62</u> .		Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Deed or title) <u>Stacy O'Keefe M.D.</u>		22b. ADDRESS <u>Malden Mo.</u>	22c. DATE SIGNED <u>5-27-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-13-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Park, Com. Mayfield Ky.</u>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <u>Lloyd Russell Higgett Ash</u>		25. DATE RECD. BY LOCAL REG. <u>5-27-62</u>	26. REGISTRAR'S SIGNATURE <u>one F & Hopkins</u>

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 Lloyd Susseel

Licensed Embalmer No. 509-Ark

P. O. Address Piggott, Ark

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.