

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-029810

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 101

FILED JUL 18 1962

VS 300
Rev. 4/59

1 1085

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Vernon</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jasper</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u> | | Length of stay in 1b <u>10 mo</u> | c. CITY OR TOWN <u>Carthage</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>State Hospital #3</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (if outside, give location) <u>730 Walnut</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED First <u>Emmett</u> Middle <u>N.</u> Last <u>Hill</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1962</u> |
| 5. SEX <u>male</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>1884?</u> |
| 9. AGE (last birthday) <u>78</u> | | IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> | IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>not known</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>not known</u> | 11. BIRTHPLACE (City and state or country) <u>not known</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>not known</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>not known</u> | | 14. NAME OF HUSBAND OR WIFE <u>Clara O. Hill</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | 17. INFORMANT Address <u>hospital records</u> |
| 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) <u>cerebral hemorrhage</u> | | | <u>seconds</u> |
| DUE TO (b) <u>arteriosclerosis, generalized</u> | | | |
| DUE TO (c) <u>—</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic brain syndrome due to circulatory disturbance due to cerebral arteriosclerosis with psychotic reaction</u> | | | 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 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 <u>—</u> a.m. <u>—</u> p.m. <u>—</u> | Month, Day, Year <u>—</u> | | |
| 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.) <u>—</u> | 20f. CITY, TOWN, OR LOCATION <u>—</u> | COUNTY <u>—</u> STATE <u>—</u> |
| 21. I attended the deceased from <u>Sept 5, 1961</u> to <u>July 11, 1962</u> and last saw her/him alive on <u>July 10, 1962</u> Death occurred at <u>6:57 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u> | | 22b. ADDRESS <u>Nevada, Mo.</u> | 22c. DATE SIGNED <u>7-11-62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>July 11</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Park</u> | 23d. LOCATION (City, town, or county) (State) <u>Carthage, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Knell Mortuary, Carthage, Mo.</u> ADDRESS <u>—</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-14-1962</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

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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 C. McLeod*

Licensed Embalmer No. 4853

P. O. Address Shady, 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.