

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034004
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 426

VS 300
Rev. 4/59

6168
20250

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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

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Length of stay in 1b <u>10 days</u>	c. CITY OR TOWN <u>Mounds</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RFD # 1</u>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W.</u> Last <u>Hayden</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-5-1881</u>
9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dahoror</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Light Industry</u>	11. BIRTHPLACE (City and state or country) <u>Eddyville, Ky.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</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 <u>Matthe Jackson</u> Address <u>Mounds, Ill.</u>
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>Pulmonary Embolus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
DUE TO (b) <u>Postoperative transurethral resection of prostate on 9-19-62</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 _____ 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>9-19-62</u> to <u>9-27-62</u> and last saw her/him alive on <u>9-27-62</u>		Death occurred at <u>4:10 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>L.P. Seelbaugh, M.D.</u> (Degree or title)		22b. ADDRESS <u>219 North Pacific Cape Girardeau, Missouri</u>	22c. DATE SIGNED <u>9-28-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-30-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shilo</u>	23d. LOCATION (City, town, or county) (State) <u>Villa Ridge, Illinois</u>
24. FUNERAL DIRECTOR <u>William T. Green</u> ADDRESS <u>Mounds, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>9-29-62</u>	26. REGISTRAR'S SIGNATURE <u>James Kasten</u>

USE BLACK INK OR TYPEWRITER RIBBON

OCT 1 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 William T. Quinn

Licensed Embalmer No. 29-10154

P.O. Address Mounds, Ill.

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.