

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-034008
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 414

FILED SEP 24 1962

VS 300
Rev. 4/59

10168
4001

3

4 1

5 2

6

7 0

8 0

9 410X

10

11

12 1-2

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>CAPE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>SCOTT</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>CHAFFEE</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>CAPE OSTEOPATHIC HOSP.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>324 E. DAVIDSON</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>CAROLINE</u> Last <u>HUGHES</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>18</u> Year <u>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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6 1902</u>
9. AGE (last birthday) <u>60</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>18</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>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and state or country) <u>NEW HAMBURG, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>LOUIS SCHOTT</u>	
13b. MOTHER'S MAIDEN NAME <u>ROSE LEE</u>		14. NAME OF HUSBAND OR WIFE <u>HOBSON DEWEY HUGHES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MRS. LUCILLE REVELLE - CHAFFEE Mo.</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>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fibrosis pericarditis with valvular lesions</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 mi</u> <u>10 yr.</u>
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 <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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>July 1960</u> to <u>9/18/62</u> and last saw her <u>him</u> alive on <u>9/18/62</u> Death occurred at <u>9:55 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Kenneth D. Bess Do. Chaffee Mo.</u>		22b. ADDRESS <u></u>	22c. DATE SIGNED <u>9/18/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT. 21, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST Hills Mem. Cem. (NEAR) MORLEY, Missouri</u>	23d. LOCATION (City, town, or county) (State) <u></u>
24. FUNERAL DIRECTOR ADDRESS <u>BISHINGHOFF FUNERAL HOME - CHAFFEE, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-20-62</u>	26. REGISTRAR'S SIGNATURE <u>Irene Kasten</u>

USE BLACK INK OR TYPEWRITER RIBBON

MAR 21 1963

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 Jack T. Burnett

Licensed Embalmer No. 4472

P. O. Address Chaffee, Missouri

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.