

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-038517

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 180

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 30 1962	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>	
2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u> Length of stay in lb <u>20 yrs.</u>	
c. CITY OR TOWN <u>West Plains</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>110 E. Leyda</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <u>110 E. Leyda</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>McCall</u> Last <u>Hanson</u>	
4. DATE OF DEATH <u>October 21, 1962</u> Month <u>October</u> Day <u>21</u> Year <u>1962</u>	
5. SEX <u>female</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>10-1-1867</u> 9. AGE (last birthday) <u>95 years</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (City and state of country) <u>Parrish of Partick, Lanarkshire, Scotland, U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>David McCall</u>	
13b. MOTHER'S MAIDEN NAME <u>Isabella Reid</u>	
14. NAME OF HUSBAND OR WIFE <u>R.H. Hanson</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>no</u>	
17. INFORMANT Address <u>Mary Kimbrough, West Plains, 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>Cerebral Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 WKS</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> <u>5 yrs</u> DUE TO (c) <u>arteriosclerosis</u> <u>15 yrs.</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 checked="" 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>6:48</u> a.m. p.m. Month, Day, Year <u>4/18/1961</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>her</u>	
20f. CITY, TOWN, OR LOCATION <u>West Plains, Missouri</u> COUNTY <u>Howell</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>4/18/1961</u> to <u>10/21/1962</u> and last saw <u>her</u> alive on <u>10/18/62</u> Death occurred at <u>6:48 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>J. Callahan M.D.</u> (Degree or title)	
22b. ADDRESS <u>West Plains, Missouri</u>	
22c. DATE SIGNED <u>10-22-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>10-23-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Richmond Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Richmond, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Robertson's, West Plains, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>10-27-62</u>	
26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

VS 300 Rev. 4/59

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NOV 14 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 *A. D. Robertson*

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.