

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-046074

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 1224

**FILED JAN 2 1963**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Butler</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Madison</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff, Mo.</u>		Length of stay in 1b	c. CITY OR TOWN <u>Fredericktown</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>VA Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>207 Saline St.</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>ALEXANDER</u> Last <u>HUSTEN</u>			4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>21</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>11-7-012</u>	9. AGE (last birthday) <u>61 YEARS</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CUSTODIAN</u>	11. BIRTHPLACE (City and state or country) <u>ST. PAUL, MINNESOTA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>ALEXANDER HUSTEN</u>		13b. MOTHER'S MAIDEN NAME <u>ALICE DEMPSEY</u>		14. NAME OF HUSBAND OR WIFE <u>ROSE HUSTEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW2</u>			16. SOCIAL SECURITY NO.	17. INFORMANT <u>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>			DUE TO (b) <u>ARTERIOSCLEROSIS</u>	INTERVAL BETWEEN ONSET AND DEATH <u>94 6 DAYS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (c)	<u>94 3 YEARS</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 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 Month, Day, Year p.m.					
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. <u>VA</u> attended the deceased from <u>DECEMBER 13, 1962</u> to <u>december 21, 1962</u> . Death occurred at <u>9:55 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Do not write in title) <u>Robert S. Cohen</u> <b>ROBERT S. COHEN M.D. Chief Med. Service</b>			22b. ADDRESS <u>VA HOSPITAL, POPLAR BLUFF, MO.</u>		22c. DATE SIGNED <u>12-27-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-22-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Snelling Nat. Cem.</u>		23d. LOCATION (City, town, or county) <u>St. Paul, Minn.</u>	
24. FUNERAL DIRECTOR <u>Frank-Cotrell Poplar Bluff, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>1-1-1963</u>	26. REGISTRAR'S SIGNATURE <u>Thelma Graham</u>	

JAN 9 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 Edgar W. Laffoon  
Licensed Embalmer No. 3394

P. O. Address Poplar Bluff 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.