

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-046548

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1912

FILED JAN 7 1963

<b>1. PLACE OF DEATH</b> a. COUNTY <u>GREENE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u> Length of stay in lb <u>2 YRS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2043 East Ave</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u> c. CITY OR TOWN <u>MARSHFIELD RI</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>9 MI NORTH WEST</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>WILLIAM</u> Middle <u>HARTMAN</u> Last <u>HARTMAN</u>		<b>4. DATE OF DEATH</b> Month <u>DEC</u> Day <u>26</u> Year <u>1962</u>				
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6-16-1868</u>	<b>9. AGE</b> (last birthday) <u>94</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <u>ILLINOIS</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
<b>13a. FATHER'S NAME</b> <u>SAMUEL HARTMAN</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>MARTHA OURNBT</u>		<b>14. NAME OF HUSBAND OR WIFE</b> _____	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>SAM HARTMAN</u> Address <u>SPRINGFIELD</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ) DUE TO (b) <u>Quintess - sclerotic cerebral</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						
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____		
<b>20c. TIME OF INJURY.</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____		<b>STATE</b> _____		
<b>21. I attended the deceased from</b> <u>2/29/61</u> to <u>12-26-62</u> and last saw <sup>her</sup> <del>him</del> alive on <u>5-13-62</u> Death occurred at <u>430 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <u>[Signature]</u>			<b>22b. ADDRESS</b> <u>[Address]</u>		<b>22c. DATE SIGNED</b> <u>1/3/62</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>REMOVED</u>		<b>23b. DATE</b> <u>12-26-1962</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MARSHFIELD</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>MARSHFIELD MO</u>	
<b>24. FUNERAL DIRECTOR</b> <u>BARBER-EDWARDS</u> ADDRESS <u>MARSHFIELD</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>1-4-63</u>		<b>26. REGISTRARS SIGNATURE</b> <u>Effie S. Melton</u>	

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

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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

*George Stapp*

Licensed Embalmer No.

*3161*

P. O. Address

*Mr. Stapp, 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.

Permit

15-26-65