

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-002383

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 981 - Primary Registration District No. 3029 Registrar's No. 297

FILED FEB 6 1963

VS 300
Rev. 4/59

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2585

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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>Linn</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u> | | Length of stay in 1b <u>64 yrs</u> | c. CITY OR TOWN <u>Brookfield</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>Pershing Hospital</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>217 W. Park</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>EDWARD HUBBARD</u> First Middle Last | | | 4. DATE OF DEATH <u>Jan. 30, 1963</u> Month Day Year |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</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>12-4-1886</u> |
| 9. AGE (last birthday) <u>76</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Realtor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Real estate</u> | 11. BIRTHPLACE (City and state or country) <u>St. Catherine, Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>Sandual Hubbard</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Suzanne Sissons</u> | | 14. NAME OF HUSBAND OR WIFE <u>Kathryn Hubbard</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. Edward Hubbard, Brookfield, Mo.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>Myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>2 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u> | | | 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 - Month, Day, Year a.m. 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. I attended the deceased from <u>1960</u> , to <u>1963</u> and last saw ^{her} <u>him</u> live on <u>1-27-63</u> Death occurred at <u>2:20 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>B. D. Howell M.D.</u> | | 22b. ADDRESS <u>Brookfield, Mo.</u> | 22c. DATE SIGNED <u>1-31-63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>2-1-1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Brookfield, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Wright Funeral Home, Brookfield, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>6-22-63</u> | 26. REGISTRAR'S SIGNATURE <u>Anna Watson</u> |

USE BLACK INK OR TYPEWRITER RIBBON

MAR 15 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 Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, 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.