

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-010614

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1469 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED APR 8 1963</b>		1. PLACE OF DEATH a. COUNTY <b>Butler</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Arkansas</b> b. COUNTY <b>Sharp</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>		Length of stay in lb <b>7 Days</b>		c. CITY OR TOWN <b>Poughseepsie</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA. Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>General Delivery</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARCHIE</b> Middle <b>EDWARD</b> Last <b>HANCK</b>			4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-23-88</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Power Shaver Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (City and state or country) <b>Huron, Ohio</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>John Hanck</b>		13b. MOTHER'S MAIDEN NAME <b>Alice Luges</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <input type="text"/>	
17. INFORMANT <b>VA. Hospital Records Poplar Bluff, Mo.</b>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> DUE TO (b) <b>CHRONIC COR PULMONALE</b> DUE TO (c) <b>TUBERCULOSIS PULMONARY - INACTIVE</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH - - - -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>G.I. BLEEDING</b>			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? <b>YES</b> <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 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. <b>NA</b> attended the deceased from <b>3-19-63</b> to <b>3-26-63</b> Death occurred at <b>9:45PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>DAVID V. GILLER</b>		(Degree or title) <b>M.D. Pathologist</b>		22b. ADDRESS <b>VA. Hospital Poplar Bluff, Mo.</b>	22c. DATE SIGNED <b>3-27-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-29-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spotts Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Poughkeepsie, Sharp, Ark.</b>	
24. FUNERAL DIRECTOR <b>Earl B. Ball</b>		ADDRESS <b>Cave City, Ark.</b>	25. DATE RECD. BY LOCAL REG. <b>4-1-1963</b>	26. REGISTRAR'S SIGNATURE <b>Delora Leaker</b>	

USE BLACK INK OR TYPEWRITER RIBBON

APR 17 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 H. Eulis Ballard, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed H. Eulis Ballard

Licensed Embalmer No. 972

P. O. Address Cass City, 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.