

FILED MAR 10 1969

DEPARTMENT OF PUBLIC HEALTH AND WELFARE — MISSOURI DIVISION OF HEALTH
(PHYSICIAN OR CORONER)

STATE FILE NUMBER

124

69-006517

CERTIFICATE OF DEATH

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 59

DO NOT WRITE
ON THIS STUBVS 300
Rev. 1/68

9. 1
10a. 84
10b.
11. 1
12. 1
13. 583X
14. 4
15. 9
16.
17.
18. 0
19. CREDITS
20. 5-0

DECEASED

USUAL RESIDENCE
WHERE DECEASED
LIVED. IF DEATH
OCCURRED IN
INSTITUTION, GIVE
RESIDENCE BEFORE
ADMISSION.

6. 1030

PARENTS

CAUSE

CERTIFIER

BURIAL

Type or print in
PERMANENT BLACK INK.
See handbook for instructions.

| | | | | | | | | | | | |
|--|--|--|-----|---|--------------|--|----------------------------------|-------------------------------|----------------------------------|--|--|
| DECEASED—NAME | | FIRST | | MIDDLE | | LAST | | SEX | DATE OF DEATH (MONTH, DAY, YEAR) | | |
| 1. Mattie | | Bell | | Hogland | | 2 Female | | 3. Feb. 24, 1969 | | | |
| RACE WHITE, NEGRO, AMERICAN INDIAN, ETC. (SPECIFY) | | AGE—LAST BIRTHDAY (YEARS) | MO. | DAYS | UNDER 1 YEAR | UNDER 1 DAY | DATE OF BIRTH (MONTH, DAY, YEAR) | COUNTY OF DEATH | | | |
| 4. White | | 5b. 84 | 10 | 29 | 5c. | 6. March 25, 1881 | 7a. Dunklin | | | | |
| CITY, TOWN, OR LOCATION OF DEATH | | INSIDE CITY LIMITS (SPECIFY YES OR NO) | | HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER) | | | | | | | |
| 7b. Kennett | | 7c. yes | | 7d. Dunklin County Memorial | | | | | | | |
| STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY) | | CITIZEN OF WHAT COUNTRY | | MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) | | SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME) | | | | | |
| 8. Miss. | | 9. U.S.A. | | 10. Married | | 11. Walter C. Hogland | | | | | |
| SOCIAL SECURITY NUMBER | | USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) | | KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 12. | | 13a. Housewife | | 13b. Home | | | | | | | |
| RESIDENCE—STATE | | COUNTY | | CITY, TOWN, OR LOCATION | | INSIDE CITY LIMITS (SPECIFY YES OR NO) | | STREET AND NUMBER | | | |
| 14a. Mo. | | 14b. Stoddard | | 14c. Dexter | | 14d. no | | 14e. Green Meadows Rest Home | | | |
| FATHER—NAME | | FIRST | | MIDDLE | | LAST | | MOTHER—MAIDEN NAME | | | |
| 15. Leroy | | --- | | Street | | 16. | | | | | |
| INFORMANT—NAME | | MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) | | | | | | | | | |
| 17a. Eldon C. Hogland | | 17b. 1570 Bluff Drive, Florissant, Mo. | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)] | | | | | | | | | |
| 18. (IMMEDIATE CAUSE) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| (a) Bilateral Pneumonia | | | | | | | | | | | |
| (b) CVA | | | | | | | | | | | |
| (c) Myocardial Infarction | | | | | | | | | | | |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (D), STATING THE UNDERLYING CAUSE LAST | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (D) | | AUTOPSY (YES OR NO) | | IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH | | | | | | | |
| ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY) | | DATE OF INJURY (MONTH, DAY, YEAR) | | HOUR | | HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18) | | | | | |
| 20a. | | 20b. | | 20c. | | 20d. | | | | | |
| INJURY AT WORK (SPECIFY YES OR NO) | | PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY) | | LOCATION | | (STREET OR R.F.D. NO., CITY OR TOWN, STATE) | | | | | |
| 20e. | | 20f. | | 20g. | | | | | | | |
| CERTIFICATION—PHYSICIAN: | | MONTH | | DAY | | YEAR | | AND LAST SAW HIM/HER ALIVE ON | | I DID/DID NOT VIEW THE BODY AFTER DEATH. | |
| 21a. I ATTENDED THE DECEASED FROM | | 5-10-58 | | TO | | 2-24-69 | | 21c. 2-24-69 | | 21d. | |
| CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED. | | HOUR OF DEATH | | THE DECEDENT WAS PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| 22a. | | M. 22b. | | M. 22c. | | M. 22d. | | M. 22e. | | M. 22f. | |
| CERTIFIER—NAME (TYPE OR PRINT) | | SIGNATURE | | DEGREE OR TITLE | | DATE SIGNED (MONTH, DAY, YEAR) | | | | | |
| 23a. W.D. English, M.D. | | 23b. [Signature] | | 23c. M.D. | | 23d. 3-3-69 | | | | | |
| MAILING ADDRESS—CERTIFIER | | STREET OR R.F.D. NO. | | CITY OR TOWN | | STATE | | ZIP | | | |
| 23e. | | 23f. Cardwell | | 23g. Mo. | | | | | | | |
| BURIAL, CREMATION, REMOVAL (SPECIFY) | | CEMETERY OR CREMATORY—NAME | | LOCATION | | CITY OR TOWN | | STATE | | | |
| 24a. Burial | | 24b. Mount Zion | | 24c. Walcott, Ark. | | | | | | | |
| DATE (MONTH, DAY, YEAR) | | FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) | | | | | | | | | |
| 24d. Feb. 27, 1969 | | 24e. McDaniel Funeral Service, Inc. Kennett, Mo. 63857 | | | | | | | | | |
| GENERAL DIRECTOR—SIGNATURE | | REGISTRAR—SIGNATURE | | DATE RECEIVED BY LOCAL REGISTRAR | | | | | | | |
| 25a. [Signature] | | 25b. Mrs. Nancy Raines | | 25c. Mar. 6, 1969 | | | | | | | |

MAR 14 1969

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 Sammy E. Roberts

Licensed Embalmer No. 4886

P. O. Address Kennett, 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.