S. No. 2
I—8-43
5-17-39
I X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 17 1944

Registration District No. 3716

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6075

State File No. 28674

Registrar's No. 125

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Farmington RURAL St. Francois Co
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. State Hospital No. 4 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 yrs. 4 mes. 23 das.
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Maries
(c) City or town Vienna
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME SAMUEL EVERETT HASTINGS (HASTING)

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Elsie Copeland

6. (c) Age of husband or wife if alive Age Unk years

7. Birth date of deceased February (Month) 8 (Day) 1885 (Year)

8. AGE: Years 59 | Months 3 | Days 12 | If less than one day ___ hr. ___ min.

9. Birthplace Vienna (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Common laborer

11. Industry or business

MOTHER
12. Name Daniel Boone Hasting

FATHER
13. Birthplace Vienna, (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Lou Verna McDaniel

15. Birthplace Vienna, (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Records State Hospital No. 4
(b) Address Farmington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Viennad Mo.

18. (a) Signature of funeral director C. H. Bucker.
(b) Address Owensville Mo.

19. (a) Aug 1 1944 (Date received local registrar) (b) [signature] (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20, year 1944 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from March 20, 1944, 19__, to May 20, 1944, 19__; that I last saw him alive on May 20, 1944, 19__; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage | |
| Due to: Generalized Arteriosclerosis | 6 yrs |
| Due to: | |
| Other conditions: Dementia Praecox. (Include pregnancy within 3 months of death) | 6 yrs |

PHYSICIAN

Major findings:
Of operations: 93a1
Of autopsy: No autopsy.

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury 0

23. Signature David Boatman (M. D. or other)
Address State Farm Date signed 5-21-44

1373 (Licensed Embalmer's Statement on Reverse Side) Farmington, Mo.

[illegible]IVED

District Health Officer No. 4

District File Number 844-422

Date Filed 8-12-44

## 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 .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed R. G. Boyer.

Licensed Embalmer No. 1671

P. O. Address Desloge 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 this body is not embalmed, fact should be so stated above.**