

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0016198

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 6070 Registrar's No. 158

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 0940  
2 0940  
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4 4054  
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12 90-2  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK  
OR  
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH COUNTY <u>St. Francois</u> <b>APPLIED 28-64</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Knob Lick</u>		c. CITY OR TOWN <u>Knob Lick</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at Residence</u>		d. STREET ADDRESS (If outside, give location) <u>Rural Rt.</u>	
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Hamm</u>			4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1964</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/1875</u>
9. AGE (last birthday) <u>89</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>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Knob Lick, Mo.</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>James Hamm</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Bayless</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Address <u>Mrs. J.E. Hollinger Knob Lick, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MEDULLARY PARALYSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN</u>
DUE TO (b) <u>CEREBRAL HEMORRHAGE</u>			<u>5 DAYS</u>
DUE TO (c) <u>ARTERIO SCLEROSIS</u>			<u>5 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>OLD AGE</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 checked="" 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. Month, Day, Year _____			
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>5-1-59</u> to <u>4-19-64</u> and last saw her/him alive on <u>4-19-64</u> Death occurred at <u>2:42</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R.A. Hendigob M.D.</u>		22b. ADDRESS <u>FARMINGTON, MO</u>	22c. DATE SIGNED <u>4-21-64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/22/1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	23d. LOCATION (City, town, or county) <u>Knob Lick Missouri</u>
24. FUNERAL DIRECTOR <u>C.H. Cozean Farmington, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>April 21 1964</u>	26. REGISTRAR'S SIGNATURE <u>Eather Rudloff</u>

2010100

STATEMENT BY LICENSED EMBALMER

**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 C. Hogan  
Licensed Embalmer No. 4084

P. O. Address Farrington 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.