

031

FILED NOV 8 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34192

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>160</u>		PRIMARY REG. DIST. NO. <u>3030</u>		Registrar's No. <u>59</u>		
1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>Festus</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>Festus</u>		d. STREET ADDRESS (If rural, give location) <u>823 Delmar</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>				d. STREET ADDRESS (If rural, give location) <u>823 Delmar</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Hartford</u>			b. (Middle)			c. (Last) <u>Dutton</u>		
4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 7, 1949</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 23, 1986</u>		
9. AGE (In years last birthday) <u>63/6/14</u>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours		IF UNDER 24 HRS. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Foreman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Mfg.</u>			11. BIRTHPLACE (State or foreign country) <u>Jefferson County, Mo.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>								
13a. FATHER'S NAME <u>Theodore Dutton</u>			13b. MOTHER'S MAIDEN NAME <u>Lucinda McCarty</u>			14. NAME OF HUSBAND OR WIFE <u>Lillie Hendrix</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>489-03-4596</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lillie Dutton</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10-49 hrs</u>	
			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) _____	
			DUE TO (c) _____					
			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>442X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>10-29, 1948</u> , to <u>9-7, 1949</u> , that I last saw the deceased alive on <u>9-3-</u> , 1949, and that death occurred at <u>4:15 p.m.</u> , from the causes and on the date stated above.								
22a. SIGNATURE <u>[Signature]</u>			(Degree or title) <u>M.D. U. Capital City Mo.</u>			23b. ADDRESS <u>9-8-49</u>		
23c. DATE SIGNED <u>9-8-49</u>								
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 9, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Roselawn</u>		24d. LOCATION (City, town, or county) (State) <u>Festus, mo.</u>		
DATE REC'D BY LOCAL REG <u>Sept. 10, 1949</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Festus Mo</u>		

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

RECEIVED  
NOV 4 1939  
District Health Officer No. 9  
District File Number

**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.

Signed \_\_\_\_\_

*[Handwritten Signature]*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3010

P. O. Address \_\_\_\_\_

*[Handwritten Address]*

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.