

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4521

State File No. _____

Tillman
FILED FEB 19 1957

BIRTH NO. _____ REG. DIST. NO. 142 PRIMARY REG. DIST. NO. 5566 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Goldsberry</u>		c. CITY OR TOWN <u>Mtn. View</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>6 days</u>		e. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hosp</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Robert</u>	b. (Middle) <u>Gerald</u>	c. (Last) <u>Haines</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 12, 1957</u>
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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>March 31, 1912</u>	9. AGE (In years last birthday) <u>44</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Television & Radio</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Repair</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Greenville, Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Ralph Haines</u>	13b. MOTHER'S MAIDEN NAME <u>Odean Carter</u>	14. NAME OF HUSBAND OR WIFE <u>Martha Haines</u>
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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. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Ralph Haines</u>	ADDRESS <u>Mount Orab, Ohio</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>		<u>2 weeks</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>Chronic pneumonia</u>		<u>10 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>6 weeks</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>416x</u> _____
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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? _____
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22. I hereby certify that I attended the deceased from 2-8, 1957, to 2-12, 1957, that I last saw the deceased alive on 2-11, 1957, and that death occurred at 12 500 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. E. Tillman M.D.</u>	23b. ADDRESS <u>Mtn. View, Mo.</u>	23c. DATE SIGNED <u>2-14-57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>2-12-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn</u>	24d. LOCATION (City, town, or county) (State) <u>Piqua, Ohio</u>
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DATE REC'D BY LOCAL REG. <u>2-16-57</u>	REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Duncan Funeral Home</u>	ADDRESS <u>Mtn View, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

126

FEB 21 1957

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 *Joel R. Duncan*
Licensed Embalmer No. *432*
P. O. Address *Mt. View*

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.