

Health,
& Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37061

STATE FILE NUMBER

FILED NOV 14 1957

Registration District No. 314 Primary Registration District No. 4458 Registrar's No. 61

S. 300
v. 1-570

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Osceola</u> TOWN		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Schell City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osceola Hospital</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>Route # 1</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>S.</u> Last <u>Hamby</u>			4. DATE OF DEATH Month <u>Oct</u> ; Day <u>24</u> , Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1880</u>		9. AGE (In years last birthday) <u>77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Junction City Kan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Doryland</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Benjamin H. Hamby</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.	17. INFORMANT Address <u>Benjamin H. Hamby, El Dorado Spgs; 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>Arteriosclerotic Heart disease & decompensation</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>					
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <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>15 Oct 57</u> to <u>24 Oct 57</u> and last saw her alive on <u>24 Oct 57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>A. Ziesler M.D.</u> (Degree or title)		22b. ADDRESS <u>Osceola Mo</u>		22c. DATE SIGNED <u>28 Oct 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-27-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>El Dorado Springs</u>		23d. LOCATION (City, town, or county) (State) <u>El Dorado Springs Missouri</u>
24. FUNERAL DIRECTOR <u>QUINN-CROTHERS</u>		ADDRESS <u>El Dorado Spgs Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-2-57</u>	
26. REGISTRAR'S SIGNATURE <u>Paul Seewers</u>					

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Flora E. Carothers*

Licensed Embalmer No. *4419*

P. O. Address *E. Daraloffing*

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.