

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023039

STATE FILE NUMBER

FILED JUN 24 1958

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 196

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>East Prairie</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #4</b>			Length of stay in 1b <b>7 mo., 4da.</b>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>E.</b> Last <b>BABB</b>				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1958</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 6, 1873</b>		9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b>	IF UNDER 24 HRS. Hours <b>5</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Art Babb</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Records, State Hospital #4, Farmington, Mo.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Abt. 14 das.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Cerebral arteriosclerosis</b>					Unknown.	
		DUE TO (c) _____					<b>33/X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with cerebral arteriosclerosis .</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
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. _____								
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 <b>October 7, 1957</b> to <b>May 11, 1958</b> and last saw <del>him</del> <sup>him</sup> alive on <b>May 11, 1958</b> Death occurred at <b>11:25 a. m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>John C. Brennan M.D.</i>				22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>			22c. DATE SIGNED <b>5-11-58</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 14, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Charleston, Mo.</b>			
24. FUNERAL DIRECTOR <b>Pravis Shelby Funeral Director East Prairie, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>May 11, 1958</b>		26. REGISTRAR'S SIGNATURE <i>Esther Rudloff</i>		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 0940 1-56 2

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Travis Shelby*  
Licensed Embalmer No. *491*

P. O. Address *Cost. P. A.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.