

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024463  
STATE FILE NUMBER

FILED AUG 4 1958

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 243

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>SULLIVAN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Green City</b> 1050 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>Grim-Smith Hospital</b>		Length of stay in lb <b>3 days</b>	d. STREET ADDRESS (If outside, give location) <b>NO STREET ADDRESS</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Loren</b> Middle <b>Charles</b> Last <b>Posey</b>			4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1958</b>		
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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>6-15-89</b>	9. AGE (In years, last birthday) <b>69</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	11. BIRTHPLACE (City and state or territory) <b>Green City, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Andrew Posey</b>	13b. MOTHER'S MAIDEN NAME <b>Carolyn Pfeiffer</b>	14. NAME OF HUSBAND OR WIFE <b>Bessie Posey</b>
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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) <b>Unknown</b>	16. SOCIAL SECURITY NO. <b>491-24-7694</b>	17. INFORMANT <b>Grim-Smith Hospital, Kirksville, Missouri</b>	Address
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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>Tetanus.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Infected injury of the right hand.</b>	
	DUE TO (c) <b>061X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>

20a. ACCIDENT <input checked="" 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.) <b>While working in his barn accidentally perforated the palm</b>
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20c. TIME OF INJURY Hour <b>7</b> Month, Day, Year <b>15-58</b> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <b>Farm.</b>	20f. CITY, TOWN, OR LOCATION <b>Green City,</b>	COUNTY <b>Sullivan</b>	STATE <b>Missouri</b>
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21. I attended the deceased from <b>7-25-58</b> to <b>7-27-58</b> and last saw <sup>him</sup> alive on <b>7-27-58</b> Death occurred at <b>5:45 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>O. L. Hasselblad</b> (Degree or title) <b>M. D.</b>	22b. ADDRESS <b>112-201 East Patterson Ave. Kirksville, Missouri</b>	22c. DATE SIGNED <b>7-28-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>7-30-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION CEMETERY</b>	23d. LOCATION (City, town, or county) <b>SULLIVAN CO.,</b>	(State) <b>MO.</b>
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24. FUNERAL DIRECTOR <b>Glenn E. Fontson, Green City, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>7-30-1958</b>	26. REGISTRAR'S SIGNATURE <b>Doris W. Ratliff</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Karl R. Feat* .....

Licensed Embalmer No. *4689* .....

P. O. Address *Green City, 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.