

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031570  
STATE FILE NUMBER

FILED AUG 25 1958 Registration District No. 371 Primary Registration District No. 6262 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>INDIANA TWP</b>		c. CITY OR TOWN <b>MARSHFIELD MO R4</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <b>7mi S.W.</b>	

3. NAME OF DECEASED (Type or print) First <b>HOMER</b> Middle <b>F</b> Last <b>HASKINS</b>			4. DATE OF DEATH Month <b>Aug</b> Day <b>16</b> Year <b>1958</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 7 1965</b>	9. AGE (In years at birthday) <b>93</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET MERCHANT</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <b>MICHIGAN 1</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13a. FATHER'S NAME <b>KAMORE HASKINS</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE _____	

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. _____	17. INFORMANT <b>ALICE CARTER MARSHFIELD R4</b> Address <b>Pulmonary edema</b>
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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>Congestive Heart Failure.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b>	
	DUE TO (c) <b>4321</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Prostatism &amp; Recurrent Pyelitis; Cerebral Vascular Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) <b>4321</b>
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____

21. I attended the deceased from <b>May 28, 1958</b> to <b>Aug 16, 1958</b> and last saw him alive on <b>July 17, 1958</b> . Death occurred at <b>1:35 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>J. M. Macdonell MD</b>	22b. ADDRESS <b>Marshfield, Mo.</b>	22c. DATE SIGNED <b>Aug 16, 1958</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8-19-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HAWLEY</b>	23d. LOCATION (City, town, or county) (State) <b>GRANT CO OKLA</b>
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24. FUNERAL DIRECTOR <b>BARBER-EDWARDS MARSHFIELD</b>	25. DATE RECD. BY LOCAL REG. <b>8-22-58</b>	26. REGISTRAR'S SIGNATURE <b>Opal M. Good</b>
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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 *George Stapp* .....

Licensed Embalmer No. *3161* .....  
P. O. Address *Wm. Bruce* .....

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.