

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032483

STATE FILE NUMBER

FILED OCT 14 1958 Registration District No. 141 Primary Registration District No. 3035- Registrar's No. 65

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <i>Waukegan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Waukegan</i>					
b. CITY OR TOWN <i>West Plains</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>West Plains</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>Charles Hayes</i>			Length of stay in <i>20 hrs</i>		d. STREET ADDRESS <i>114 Littlewood</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <i>Laura Pet Jacket</i>				4. DATE OF DEATH Month Day Year <i>9-23-58</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-14-1887</i>		9. AGE (In years last birthday) <i>71</i> IF UNDER 1 YEAR Months <i>1</i> Days <i>17</i> IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>West Plains Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13a. FATHER'S NAME <i>J. K. May</i>				13b. MOTHER'S MAIDEN NAME <i>Mary Lytle</i>				14. NAME OF HUSBAND OR WIFE <i>Reuben Arnold Salina Ks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>Reuben Arnold Salina Ks</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>							INTERVAL BETWEEN ONSET AND DEATH <i>24 Hours</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____							DUE TO (c) <i>331X</i>		
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"/>		
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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <i>22-9-58</i> to <i>23-9-58</i> and last saw <i>her</i> alive on <i>23-9-58</i> . Death occurred on <i>6:40 PM</i> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>[Signature]</i> (Degree or title) <i>MD</i>				22b. ADDRESS <i>West Plains, Mo</i>				22c. DATE SIGNED <i>SEP 30 1958</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>7-25-58</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion</i>		23d. LOCATION (City, town, or county) (State) <i>White Church Mo</i>			
24. FUNERAL DIRECTOR <i>Robertson, West Plains Mo</i>				25. DATE RECD. BY LOCAL REG. <i>10-10-58</i>		26. REGISTRAR'S SIGNATURE <i>Bessie Cook</i>			

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *A. A. Roberts*

Licensed Embalmer No. *3437*
P. O. Address *West Hill*

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.