

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045908
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 297 Primary Registration District No. 6021 Registrar's No. 170

FILED JAN 2 1962

1. PLACE OF DEATH a. COUNTY <u>Ray County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>RAY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grape Grove Twp</u>			Length of stay in lb <u>LIFE</u>		c. CITY OR TOWN <u>Norborne</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>A.R.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>A.R.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Barton</u> Last <u>HULTZ</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>male</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>1-22-1880</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>PARSONS, KANS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>S. D. HULTZ</u>			13b. MOTHER'S MAIDEN NAME <u>SABINA STEELE</u>		14. NAME OF HUSBAND OR WIFE <u>JANNIE HULTZ</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. <u>493-26-4195</u>		17. INFORMANT <u>Mrs. Frank Hultz Norborne 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>Carcinoma of prostate with metastases to long bones - vertebrae</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m.		Month, Day, Year _____		_____			
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 <u>Dec. 24, 1961</u> to <u>Dec 26, 1961</u> and last saw her/him alive on <u>Dec. 24, 1961</u> Death occurred at <u>1 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. E. Goldberg M.D.</u>				22b. ADDRESS <u>Blayman, Mo.</u>		22c. DATE SIGNED <u>12/26/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec 27, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		23d. LOCATION (City, town, or county) (State) <u>CARROLL MO</u>		
24. FUNERAL DIRECTOR <u>DICKERSON-RICE - BOGARD, MO</u>			25. DATE RECD. BY LOCAL REG. <u>12-28-1961</u>		26. REGISTRAR'S SIGNATURE <u>Malcol Jackson</u>		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 ^dby _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Samuel M. Rice

Licensed Embalmer No. 5087

P. O. Address Boyard, 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.