

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-007292

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 155 Primary Registration District No. 5578 Registrar's No. 27

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

ROBERT G. MEDICAL CERTIFICATION M.D.

FILED FEB 19 1963					
1. PLACE OF DEATH a. COUNTY <u>Jasper</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joplin Twp.</u> Length of stay in lb <u>1 Mo.</u>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hope Manor Rest Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jasper</u>					
c. CITY OR TOWN <u>Galena, Kansas</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
d. STREET ADDRESS (If outside, give location) <u>Rt 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED First Middle Last			4. DATE OF DEATH Month Day Year		
<u>Roscoe E. Hetherington</u>			<u>2 9 1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-1880</u>	9. AGE (last birthday) <u>82</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Newton Co., Mo.</u>	
13a. FATHER'S NAME <u>Alvin Hetherington</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Goforth</u>		14. NAME OF HUSBAND OR WIFE <u>Grace Hetherington (deceased)</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>[redacted]</u>		17. INFORMANT <u>Clyde Hetherington, Webb City, Mo.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Short</u>
DUE TO (b) <u>Generalized Arteriosclerosis</u>					<u>20 yrs</u>
DUE TO (c) <u>Diabetes Mellitus</u>					<u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Recent Amputation Rt leg, Arteriosclerosis Gangrene</u>					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>1950</u> to <u>9 Feb 63</u> and last saw ^{her} him alive on <u>8 Feb 63</u> Death occurred at <u>6:10 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert G. [Signature] M.D.</u>			22b. ADDRESS <u>Joplin Mo</u>		22c. DATE SIGNED <u>12 Feb 63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-12-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		23d. LOCATION (City, town, or county) (State) <u>Galena Kansas</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hurlbut-Mix Funeral Home, Joplin, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>2-12-63</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Madeline Schitzen</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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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 George L. Smith

Licensed Embalmer No. 5175

P. O. Address Josephine 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.