

FILED SEP 20 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29695

5185 State File No. 3010 Registrar's No. 2181

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <i>Cape Girardeau</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i> b. COUNTY <i>Cape Girardeau</i>	
b. CITY (If outside corporate limits, write RURAL and give township) <i>Rural, Cape Girardeau</i>		c. CITY (If outside corporate limits, write RURAL and give township) <i>near Burfordville</i> 0160	
c. LENGTH OF STAY (in this place) <i>—</i>		d. STREET ADDRESS (If rural, give location) <i>3 miles east</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Died in Ambulance</i>			

3. NAME OF DECEASED (Type or Print) a. (First) <i>Viola Lucille</i> b. (Middle) <i>Hutson</i> c. (Last) <i>Hutson</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>Sept 9, 1950</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <i>married</i>	8. DATE OF BIRTH <i>Dec 1, 1921</i>	9. AGE (In years) last birthday <i>28</i>	10. F UNDER 1 YEAR Days	11. F UNDER 18 HRS. Hours	12. COUNTRY OF WHAT COUNTRY? <i>U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeping</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Burfordville Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	

13a. FATHER'S NAME <i>Troy Crader</i>	13b. MOTHER'S MAIDEN NAME <i>Elna Masters</i>	14. NAME OF HUSBAND OR WIFE <i>Penkston Hutson</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Penkston Hutson, Jackson Mo R#2</i>		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Laceration of Throat &amp; Loss of Blood</i>		INTERVAL BETWEEN ONSET AND DEATH  <i>40810 1/2</i> <i>26</i>
	ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
	DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>016</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>Accident</i>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Highway 61 w of Jackson</i>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>Jackson, Byrd Cape Gir Mo.</i>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Sept. 9, 50 10 P.M.</i>	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Automobile Accident</i> nMVeh.

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <i>E. B. ...</i>	(Degree or title) <i>Coroner 3</i>	23b. ADDRESS <i>4 south Pacific, st. Cape Gir.</i>	23c. DATE SIGNED <i>Sept. 14, 50</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>Sept 11, 1950</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Russell Heights</i>	24d. LOCATION (City, town, or county) (State) <i>Jackson Mo</i>
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DATE REC'D BY LOCAL REG. <i>9-14-1950</i>	REGISTRAR'S SIGNATURE <i>C. C. ...</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>R. Miller</i>	ADDRESS <i>Jackson Mo</i>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

SEP 18 1950

HEALTH OFFICE No. 1

o 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 by.....

working under my personal supervision.

Student Embalmer No. ....

Signed *Lynn Steele*

Signed.....  
Student Embalmer

Licensed Embalmer No. *2476*

P. O. Address *Dickinson, N.D.*

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 this body is not embalmed, fact should be so stated above.