

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-045260  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 458

**FILED NOV 23 1965**

VS 300 Rev. 4/59	DATE AMENDED	1	0940
2		0940	
3			
4		1	
5		2	
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7		0	
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9		422.2	
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11			
12		90-2	
13		1-2	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>SE. FRANCOIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FARMINGTON RT#2</u>		c. CITY OR TOWN <u>FARMINGTON RT#2</u>	
Length of stay in lb		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>ST. FRANCOIS TWP.</u>		d. STREET ADDRESS (if outside, give location) <u>RURAL ROUTE#2</u>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>MARY LOUISE HUTCHINGS</u>			4. DATE OF DEATH Month Day Year <u>Nov. 13, 1965</u>
5. SEX <u>Female</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>1/5/1887</u>
9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Lawrenceton, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>United States</u>		13a. FATHER'S NAME <u>Siegfried Carrow</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Hughes</u>		14. NAME OF HUSBAND OR WIFE <u>William E. Hutchings</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.	
17. INFORMANT <u>Aubrey Hutchings Farmington, Mo.</u>		Address	
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>Acute circulatory failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Mins.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Congestive heart failure</u> <u>2 weeks</u>
DUE TO (c) <u>Myocardial insufficiency</u> <u>3 to 4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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>11-24-59</u> to <u>11-13-65</u> and last saw her alive on <u>11-12-65</u> Death occurred at <u>3:05 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>R.A. Medjick M.D.</u>		22b. ADDRESS <u>17 S. Jackson, Farmington, Mo.</u>	22c. DATE SIGNED <u>11-15-65</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/15/1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Marvin Chapel</u>	23d. LOCATION (City, town, or county) (State) <u>Near Bonne Terre Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>C.H. Cozean Farmington, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 15, 1965</u>	26. REGISTRAR'S SIGNATURE <u>Ether R. Rudloff</u>

NOV 24 1965

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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 C. Hozean

Licensed Embalmer No. 4084

P. O. Address Farrington, 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.