

FILED AUG 31 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26231

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 316

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>ARKANSAS</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CORNING</u>	
c. LENGTH OF STAY (in this place) <u>1 week</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lucy Lee Hospital</u>		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print) <u>Sherman</u>	a. (First)	b. (Middle)	c. (Last) <u>TALKINGTON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 16 1949</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>August 27, 1870</u>	9. AGE (In years last birthday) <u>79</u>	If under 1 year: Months _____ Days _____	If under 1 hrs. Hours _____ Min. _____
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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>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>FANNIE FRANCIS TALKINGTON</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Heyschel TALKINGTON</u>	ADDRESS <u>CORNING ARK.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CEREBRAL HEMORRHAGE</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>331X</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 8 Aug, 1949, to 16 Aug, 1949, that I last saw the deceased alive on Aug 16, 1949, and that death occurred at 10:29A m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Poplar Bluff Mo</u>	23c. DATE SIGNED <u>8/16/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE _____	24c. NAME OF CEMETERY OR CREMATORY <u>Corning Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>CORNING ARK.</u>
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DATE REC'D BY LOCAL REG. <u>Aug 25, 1949</u>	REGISTRAR'S SIGNATURE <u>Wm. H. Johnson</u> <u>428</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>CORNING ARK.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Russell's Mortuary, Corning, Ark.

MSG 30 REC'D

849-248

BUTLER COUNTY HEALTH CENTER  
POPLAR BLUFF, MISSOURI

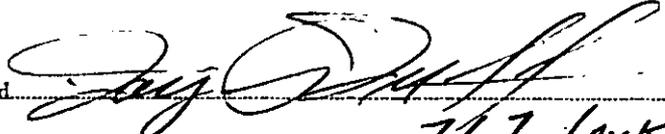
STATEMENT BY LICENSED EMBALMER

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 .....  
Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 767 (ARK)

P. O. Address CANNING, ARK.

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.