

FILED DEC 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36804**
Rodman

BIRTH NO.		REG. DIST. NO. 108		PRIMARY REG. DIST. NO. 2423		Registrar's No. 26	
1. PLACE OF DEATH a. COUNTY Dunklin b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Arbyrd Rural Rte 1 c. LENGTH OF STAY (in this place) 1 year d. FULL NAME OF HOSPITAL OR INSTITUTION Residence				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY Dunklin c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Arbyrd, Rte 1 d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) Andrew b. (Middle) Edward c. (Last) Naughton			4. DATE OF DEATH (Month) (Day) (Year) October 28 1949		5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		
8. DATE OF BIRTH January 19, 1910		9. AGE (In years last birthday) 39		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm work		11. BIRTHPLACE (State or foreign country) Fulton Co Arkansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William Franklin Naughton		13b. MOTHER'S MAIDEN NAME Harriet Elizabeth Wren		14. NAME OF HUSBAND OR WIFE Ella Naughton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY # 430-14-9449		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Ernest Naughton - Leachville, Arkansas			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Unknown ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Dead on arrival DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1/2 hr 7:15	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from never , 19___, to ____, 19___, that I last saw the deceased alive on ____, 19___, and that death occurred at 11:00 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE T H Rodman M.D. (Degree or title)				23b. ADDRESS Leachville Ark		23c. DATE SIGNED 4 Nov 49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
Burial				Leachville Cemetery		Senath, Mo Rte 1	
DATE REC'D BY LOCAL REG. 11-12-49		REGISTRAR'S SIGNATURE Mrs J H Ramirez		25. FUNERAL DIRECTOR'S SIGNATURE Howard Funeral Service - Leachville, Ark		ADDRESS	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED NOV 25 19
District Health Office No.
District File Number 1149-11
Date Filed _____

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.

Signed _____

H. H. Howard

Signed _____

Student Embalmer

Licensed Embalmer No. _____

3959

P. O. Address _____

Leachville, 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.