

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

89357
BIRTH NO. III 10 1953

REG. DIST. NO. 241 PRIMARY REG. DIST. NO. 4360 Registrar's No. 22

121

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

1. PLACE OF DEATH a. COUNTY New Madrid		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give township) Rur Portageville.		c. CITY (If outside corporate limits, write RURAL and give township) Rural Como Twsp.	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 3 miles NW. of Catron	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Ernestine b. (Middle) Parrow c. (Last) Parrow			4. DATE OF DEATH (Month) (Day) (Year) June 20 1953		
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH Dec. 23 1952		9. AGE (In years last birthday) 5 Months 27 Days		10. UNDER 1 YEAR OF AGE (In hrs. Mins.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Como-New Madrid Co., Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Gaither Lee Parrow	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Robert Parrow-Parma, Mo.		18. ADDRESS			

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) Gastro-Enteritis				INTERVAL BETWEEN ONSET AND DEATH 1.0 days	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) poor method of feeding				2 mo	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) malnutrition				2 mo	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		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 June 10, 1953, to June 20, 1953, that I last saw the deceased alive on June 15, 1953, and that death occurred at 9 P. M., from the causes and on the date stated above.

23a. SIGNATURE E. E. Jones M.D.		(Degree or title)		23b. ADDRESS Lilbourn Mo		23c. DATE SIGNED June 23 53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-21-53		24c. NAME OF CEMETERY OR CREMATORY Simmons Burial Park		24d. LOCATION (City, town, or county) (State) Catron, Mo.	

DATE REC'D BY LOCAL REG. 7-6-53		REGISTRAR'S SIGNATURE Ellis De Lisle		25. FUNERAL DIRECTOR'S SIGNATURE Ponder Funeral Home-Lilbourn, Mo.		ADDRESS	
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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
Student Embalmer

Signed

Not Embalmed
Homer L. Ponder

Licensed Embalmer No. *3367*

P. O. Address *Tillbourn, 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 this body is not embalmed, fact should be so stated above.