

Health, Welfare, Public Service  
 000-56  
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

445

FILED JAN 10 1957

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 5143 Registrar's No. 83

1. PLACE OF DEATH a. COUNTY <u>Butler</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Butler</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff Twsp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Wappapello, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Poplar Bluff Twsp.</u>		Length of stay in 1b <u>11 yrs.</u>	d. STREET ADDRESS <u>Williamsville RR2</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>LOUISE</u> Last <u>MABREY</u>			4. DATE OF DEATH <u>1-2-1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-29-1896</u>	9. AGE (In years last birthday) <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Resort Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Resort Business</u>	11. BIRTHPLACE (City and state or country) <u>Bollinger County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Millard F. Mabrey</u>			14. MOTHER'S MAIDEN NAME <u>Nancy Scott</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> <u>None</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Clyde Mabrey Millington, Tenn.</u>		
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>XXXXXXXXXXXXXXXXXXXXXXXXX</u> <u>CORONARY INFRACTION</u>					INTERVAL BETWEEN ONSET AND DEATH <u>17</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>4201</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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. _____					
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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>1-2-57 3 am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John R. Greer</u> (Degree or title)			22b. ADDRESS <u>Poplar Bluff, Mo.</u>		22c. DATE SIGNED <u>1-4-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-5-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Poplar Bluff, Mo.</u>
24. FUNERAL DIRECTOR <u>Greer Croy &amp; Fitch Funeral Home</u> <u>Poplar Bluff, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>1/4/57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

JAN 7 - 1967

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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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 *Ray P. Adams* \_\_\_\_\_

Licensed Embalmer No. *492*

P. O. Address *Poplar Bluff*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.