

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3407

FILED JAN 23 1957

STATE FILE NUMBER

Registration District No. 391 Primary Registration District No. 4505 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bell City Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Perkins, Missouri</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Shetley Nursing Home</u>		Length of stay in hospital, give location) <u>3 Months</u>	d. STREET ADDRESS (If outside, give location) <u>103</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>A</u> Last <u>Head</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Jul 1889</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Mayfield, Ky.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Sherman Head</u>			14. MOTHER'S MAIDEN NAME <u>Nancy Gills</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. <u>497-18-1328A</u>		17. INFORMANT Address <u>Mrs Paul Arnold, Perkins MO</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>Brain tumor also ligatures</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Resembling Epilepsy, Arteriosclerosis</u>	
	DUE TO (c) <u>Sensibility</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		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 <u></u> Month, Day, Year <u></u> a. m. <u></u> p. m. <u></u>						
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>1940</u> to <u>Jan 7, 1957</u> and last saw her alive on <u>Jan 6, 1957</u> Death occurred at <u></u> m on the day <u></u> stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>E. C. Masters</u>		22b. ADDRESS <u>Advance, Mo.</u>		22c. DATE SIGNED <u>Jan. 15, 1957</u>		

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10 Jan 57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Perkins New Cemetery</u>	23d. LOCATION (City, town, or county) <u>Perkins Mo</u>
24. FUNERAL DIRECTOR <u>Coy Shetley, Bell City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1/17/57</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Moore</u>

(Licensed Embalmer's Statement on Reverse Side)

with, all, public service, 100-56, Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms were observed. No symptoms were observed. Coroner cannot certify to a death due to natural causes. diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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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 *Raymond L. Duffe*.....

Licensed Embalmer No. *47*

P. O. Address *Berne*

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.