

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8140

STATE FILE NUMBER

FILED APR 1 - 1957

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 52

1. PLACE OF DEATH a. COUNTY, <u>Dunklin</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Malden</u> <u>03500</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dunklin County Hosp.</u>			Length of stay in lb <u>1 day</u>		d. STREET ADDRESS (If outside, give location) <u>Route 2</u>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>D.</u> Last <u>CHOAT</u>			4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15 1882</u>	9. AGE (In years last birthday) <u>75</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>Stonefort, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Marion Choat</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Teal</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>None</u>		17. INFORMANT <u>Clifford Choat</u> Address <u>Malden, Mo. Route 2</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>Myocardial Failure</u> Conditions, if any, which gave rise to above, cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Cardio Vascula Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 wks 5 d</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. _____ Month _____ Day _____ Year _____					
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>March 17, 1957</u> to <u>March 18, 1957</u> and last saw ^{him} <u>alive on March 18, 1957</u> Death occurred at <u>7:45 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>George O. Summers M.D.</u>			22b. ADDRESS <u>Kennett, Mo</u>		22c. DATE SIGNED <u>3-22-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>March 20 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Malden Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Landess Funeral Home, Campbell, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>3-23-57</u>	26. REGISTRAR'S SIGNATURE <u>Earl H. ...</u>	

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 health, Welfare public service
 Doctor, coroner, etc. must use only standard nomenclature in report. No symptoms with no natural causes. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED DUNKLIN COUNTY HEALTH
DEPARTMENT 3-28-5
COUNTY FILE NUMBER 357-

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by, Student Embalmer No.

working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Christine M. Lunde*

Licensed Embalmer No. 42

P. O. Address *Camp*

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.