

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9434

STATE FILE NUMBER

FILED MAR 29 1957

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 22

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Mississippi Co</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Michigan</u> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Charleston</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Flint</u>		8210 8	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>906 State St</u>			Length of stay in lb <u>3 Month</u>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Beulah</u> Middle _____ Last <u>Ervin</u>				4. DATE OF DEATH <u>Feb, 26, 1957</u> Month _____ Day _____ Year _____			
5. SEX <u>Female</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>April, 15, 1891</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Massack Co Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Jerry Minter</u>			14. MOTHER'S MAIDEN NAME <u>Dont Know</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 Address <u>Mrs Archie Forbey Charleston 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>Ac. Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) _____	
DUE TO (c) <u>Arterio-sclerotic heart disease</u>						DUE TO (d) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4200</u>						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 _____ Month _____ Day _____ Year _____ 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 on <u>2/26/57</u> to _____ and last saw her <u>alive</u> on <u>2-26-57</u> Death occurred at <u>3:00A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>E. Charles Forbey M.D.</u>			22b. ADDRESS <u>Charleston Mo</u>		22c. DATE SIGNED <u>2/28/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 28, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Morley Cemt</u>		23d. LOCATION (City, town, or county) (State) <u>Morley Mo.</u>			
24. FUNERAL DIRECTOR <u>L. L. Haman</u> ADDRESS <u>Cape Girardeau Mo</u>			25. DATE RECD. BY LOCAL REG. <u>3-21-57</u>	26. REGISTRAR'S SIGNATURE <u>Donachy B. Hathorn</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Miss. Co. Health Dep
County File No. _____
Date Filed 3-27-57

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 L.L.Haman *L.L.Haman*

Licensed Embalmer No. 2863

P. O. Address Cape Girard

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.