

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 25 1957

STATE FILE NUMBER

Registration District No. 238 Primary Registration District No. 4355 Registrar's No. 14

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>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>New Madrid</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>New Madrid</u> <u>0721</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) INSTITUTION <u>None</u>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>Second St.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Early C. Flournoy</u>				First		Middle		Last		4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>2</u> <u>Male</u>		6. COLOR OR RACE <u>Colored</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>June 14 1886</u>		9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Tennessee</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Harlinda M. Flournoy</u>						14. MOTHER'S MAIDEN NAME <u>Amanda High</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.		17. INFORMANT <u>Harlinda M. Flournoy Fennville, Mich</u> Address					
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>Cardiac decompensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiac Hypertension</u> DUE TO (c) <u>Cirrhosis of Liver</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5810</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>18 months</u> <u>3 years</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 Month, Day, Year a. m. p. m.											
20d. INJURY OCCURRED WHILE AT <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>3-12-53</u> to <u>2-27-57</u> and last saw her/him alive on <u>2-26-57</u> Death occurred at <u>1:15</u> <u>P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>James O. Cameron</u> (Degree or title)						22b. ADDRESS <u>D. O. Merston - Mo</u>			22c. DATE SIGNED <u>3-2-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)				
<u>Burial</u>		<u>Mar. 2, 1957</u>		<u>Sand Hill Cemetery</u>			<u>New Madrid, Missouri</u>				
24. FUNERAL DIRECTOR <u>Ponder Funeral Home Lilbourn, Mo</u> ADDRESS					25. DATE RECD. BY LOCAL REG. <u>5 March 57</u>		26. REGISTRAR'S SIGNATURE <u>Fay Hedgycott</u>				

512 (1)

APR 2 1957  
MAR 2 1957

2561 G & TRC

DATE RECEIVED MAR 11 1957  
NEW MADRID CO. HEALTH CENTER

P. J. S.

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 Tommy L. Roberts  
Licensed Embalmer No. 4886  
P. O. Address New Madrid

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.