

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12670

FILED MAY 13 1957

STATE FILE NUMBER

Registration District No. 109 Primary Registration District No. 4180 Registrar's No. 141

Health,  
Welfare  
Public  
Services

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>Dunklin</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>Campbell</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Parma</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		Length of stay in lb <u>3 months</u>	
d. STREET ADDRESS		(If outside, give location) <u>0720</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Francis</u> Last <u>Keith</u>			4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1957</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>cauc.</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>Nov. 1, 1881</u>
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Hickman Ky.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas B. Shaw</u>	
14. MOTHER'S MAIDEN NAME <u>Elizebeth Doughaday</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. J. E. Cook Campbell 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>Cerebral Thrombosis &amp; Right Hemiplegia</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>General Arteriosclerosis</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>10 days</u> <u>? years</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 from <u>4/22/57</u> to <u>4/24/57</u> and last saw <sup>her</sup> <del>him</del> alive on <u>4/24/57</u> Death occurred at <u>3:00 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wallace A. Belsey M.D.</u>		22b. ADDRESS <u>Campbell Mo.</u>	
22c. DATE SIGNED <u>4/30/57</u>			
23a. BURIAL, CREMATION, REMOVAL, ETC. (Specify)		23b. DATE	
<u>Burial</u>		<u>April 26, 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Smith Cemetery</u>		<u>Caruthersville Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Watkins Fun. Ser. Parma Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-29-1957</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Dulah Campbell</u>			

RECEIVED DUNKLIN COUNTY HEALTH  
DEPARTMENT..... 5-7-57  
COUNTY FILE NUMBER..... 557-

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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 *Earl Matthews*

Licensed Embalmer No. *496*

P. O. Address *Dexter Mo*

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.