

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14786

FILED APR 26 1957

318

1003

STATE FILE NUMBER

3657

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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 o. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Arkansas</b> b. COUNTY <b>Jackson</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Newport</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Length of stay in 1b <b>7 Hrs.</b>		33 <sup>d</sup> STREET ADDRESS (If outside, give location) <b>706 Newport Ave.</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>JANE</b> Last <b>HEARD</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>16</b> Year <b>1957</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 7, 1926</b>		9. AGE (In years last birthday) <b>30</b>		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) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Newport, Arkansas.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>F. A. Lochard</b>						14. MOTHER'S MAIDEN NAME <b>Jeanette Gilbreth</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W. W. # 2</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>George Heard, 706 Newport Ave.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPOTENSIVE SHOCK</b>								<b>Newport, Arkansas</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>HYPERVENTILATION</b>		DUE TO (c) <b>CONVERSION Hysteria</b>		<b>3/11/57</b>		<b>4 YEARS</b>					
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 checked="" type="checkbox"/> NO <input 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 <b>JANUARY 27, 1957</b> <b>APRIL 16, 1957</b> and last saw her alive on <b>APR 16, 1957</b> Death occurred at <b>2:50 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>C. D. Vanillion, M.D.</i> (Degree or title) <b>M. D.</b>						22b. ADDRESS <b>BARNES HOSPITAL</b>				22c. DATE SIGNED <b>4/16/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>4-16-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Grove Cemetery</b>				23d. LOCATION (City, town, or county) <b>Newport, Arkansas</b>		(State)			
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe 4700 Washington,</b>						25. DATE RECD. BY LOCAL REG. <b>APR 16 '57</b>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MO</i>					

1000

110

12

1000

1000

Newport

X

706 Newport Ave.

NEWPORT, ARKANSAS

Oct. 7, 1926

White

1000

Newport, Arkansas

At home

Housework

Josephine Elliott

T. A. Lockwood

George Henry for Newport Ark

NEWPORT

Arkansas

1000

Newport, Arkansas

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 *Elliott H. Pennington*

Licensed Embalmer No. *422*

P. O. Address *St. Louis*

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.

Albert P. ...