

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 24 1957

STATE FILE NUMBER

Registration District No. 217 Primary Registration District No. 4329 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miss.</u>												
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wyatt</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Wyatt</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>										
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>P. O. Box 317</u>			Length of stay in lb <u>30 yrs.</u>		d. STREET ADDRESS <u>P.O.Box 317</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Jim</u> Middle <u>Love</u> Last <u>Love</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>												
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</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>Oct. 12, 1891</u>		9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) <u>West Point, Miss.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unk.</u>						14. MOTHER'S MAIDEN NAME <u>Unk.</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 Address <u>Clay Baker, P.O.Box 317, Wyatt, 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>Bilateral Lobar Pneumonia</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>						
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) _____						
										DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>490x</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 _____ 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>30 Apr 57</u> to <u>5 May 57</u> and last saw <u>him</u> alive on <u>5 May 57</u> Death occurred at <u>5:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.																
22a. SIGNATURE <u>John R Sample M.D.</u> (Degree or title)						22b. ADDRESS <u>Charleston, Mo.</u>				22c. DATE SIGNED <u>8 May 57</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>May 12, 1957</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>							
24. FUNERAL DIRECTOR <u>Mrs. F. J. Sparks</u>					ADDRESS <u>Charleston, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>5-17-57</u>			26. REGISTRAR'S SIGNATURE <u>Dorothy B. Hachorn</u>					

RECEIVED
Miss. Co. Health Dept
County File No. _____
Date Filed 5-22-57

MAY 24 1957

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 *Edward H. Puffer*

Licensed Embalmer No. 5022
2501 Poplar St.
P. O. Address Cairo, Ill.

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.