

Health, Welfare & Public Service

300
1-56

ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Factory, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34988

STATE FILE NUMBER

XC-124 98 52
REG.# 15061

FILED OCT 18 1957
Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 583

1. PLACE OF DEATH a. COUNTY BUTLER			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY MADISON		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN FREDERICKTOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL		Length of stay in lb 24 DAYS	d. STREET ADDRESS (If outside, give location) GENERAL DELIVERY		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BOIM Middle (NMI) Last ST. CLAIR			4. DATE OF DEATH Month OCTOBER Day 6 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-91	9. AGE (In years last birthday) 66 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) WATCH MAKER		10b. KIND OF BUSINESS OR INDUSTRY WATCH MAKER		11. BIRTHPLACE (City and state or country) MADISON CO., MISSOURI	
13. FATHER'S NAME COLUMBUS ST. CLAIR			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME MARY ARNETT			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		
16. SOCIAL SECURITY NO. 490249377		17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION. 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) 1. ACUTE GASTRIC ULCER. 2. PRE-RENAL AZOTEMIA. 3. CHRONIC MALNUTRITION					INTERVAL BETWEEN ONSET AND DEATH 15-30 Mins.
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. <input checked="" type="checkbox"/> attended the deceased from Sept. 12, 1957 to October 6, 1957 Death occurred at 5:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Robert S. Cohen, M.D. (Print or type) ROBERT S. COHEN, M.D., Chief, Medical Svc.			22b. ADDRESS VA HOSPITAL, POPLAR BLUFF, MO.		22c. DATE SIGNED 10/7/57
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/8/57	23c. NAME OF CEMETERY OR CREMATORY MARCUS MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) MADISON COUNTY, MO.
24. FUNERAL DIRECTOR NAJIM FUNERAL HOME		ADDRESS FREDERICKTOWN MO.	25. DATE RECD. BY LOCAL REG. 10/16/57		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED

OCT 14 1957
BUTLER CO. HEALTH CENTER

FILE No. _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Charles W. Garty*

Licensed Embalmer No. 48

P. O. Address *Fredrickton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.