

pt. Health,
& Welfare
S. Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI

39827

FILED DEC 6 - 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 104 Primary Registration District No. 5418 Registrar's No. 29

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dunklin</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Cotton Hill</u>		Inside Limits, Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Rural</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Residence</u>		Length of stay in lb <u>12 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>N.W. of Malde about 3 mi</u>		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>John H Varvell</u>			4. DATE OF DEATH Month Day Year <u>11-22-57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>1889-3-12</u>	9. AGE (In years last birthday) <u>68-8-10</u>	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) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13a. FATHER'S NAME <u>John Varvell</u>		13b. MOTHER'S MAIDEN NAME <u>Earlene Barnes</u>		14. NAME OF HUSBAND OR WIFE <u>Lizzie Varvell</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. <u>526-16-1964</u>		17. INFORMANT Address <u>Woodrow A Varvell - Malden Mo RE</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 Hemorrhage -</u>					INTERVAL BETWEEN ONSET AND DEATH <u>11-15-57</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>2 weeks Hemorrhage - Paralyzed 1 mile for 5 yrs</u>					
DUE TO (c) <u>Had Diabetes for 10 yrs</u>					
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>260X</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>March 3-57</u> to <u>11-22-57</u> and last saw her ^{him} alive on <u>11-20-57</u> Death occurred at <u>1105 A. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deceased or title) <u>D. S. Calkatom D.O.</u>			22b. ADDRESS <u>Malden Mo</u>		22c. DATE SIGNED <u>11/23/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-24-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Malden Park Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>North of Malden Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Thomas C Knight Malden Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-29-57</u>	26. REGISTRAR'S SIGNATURE <u>J. D. Schumann</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

37-0

LIVED DUNKLIN COUNTY HEALTH

DEPARTMENT 12-9-51

COUNTY FILE NUMBER 1257-296

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 Thomas C. Knight

Licensed Embalmer No. 2189

P. O. Address Malden 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.