

Health,  
& Welfare  
S. Public  
Health Service

S. 300  
v. 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

FILED DEC 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
**43791**

Registration District No. 69 Primary Registration District No. 5272 Registrar's No. 109

1. PLACE OF DEATH (Where deceased lived. If institution? Residence before admission)				2. USUAL RESIDENCE (Where deceased lived. If institution? Residence before admission)				
a. COUNTY <u>Christian</u>				a. STATE <u>Arkansas</u> b. COUNTY <u>Crawford</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Porter Twsp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Van Buren</u>		02 <sup>8</sup> Inside Limits Res. <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence of Jesse Payne</u>			Length of stay in lb <u>8 years</u>	d. STREET ADDRESS <u>no street address</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First <u>ALTA</u> Middle <u>MILLS</u> Last <u>MILLS</u>				Month <u>Dec.</u> Day <u>5</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Dec. 5, 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>Cauthron, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Joseph Abbott</u>				14. MOTHER'S MAIDEN NAME <u>Alice Wood</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Jesse Payne, RFD, Nixa, 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>medullary failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>toxemia</u>		DUE TO (c) <u>Hypostatic pneumonia</u>		4 days	4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephritis acute, senility</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 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>9-2-54</u> to <u>12-5-57</u> and last saw her <sup>heart</sup> alive on <u>12-4-57</u> Death occurred at <u>3:40</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Harold Shaffer D.D.</u> (Degree or title) <u>2</u>				22b. ADDRESS <u>Nixa, Mo.</u>		22c. DATE SIGNED <u>12-11-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/5/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fentress Mortuary</u>		23d. LOCATION (City, town, or county) (State) <u>Ft. Smith, Arkansas</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Harris Funeral Home, Clever, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Dec. 15, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Oliver Heetter</u>			

(Licensed Embalmer's Statement on Reverse Side)

JAN 2 1958  
FEB 5 1958

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 John Harris

Licensed Embalmer No. 4399

P. O. Address Cleveland

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.