

pt. Health,  
c., & Welfare  
S. Public  
alth Service

*D. Halcomb*

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

A52399  
STATE FILE NUMBER

FILED DEC 23 1957

Registration District No. *267* Primary Registration District No. *3049* Registrar's No. *26*

1. PLACE OF DEATH a. COUNTY <i>Permisit</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Permisit</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Wayti</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Caruthersville</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Memorial Hosp</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>Route 1</i> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Melba</i> Middle <i>Jean</i> Last <i>Johnson</i>			4. DATE OF DEATH Month <i>12</i> Day <i>-1</i> Year <i>57</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-10-57</i>		9. AGE (In years last birthday) Months <i>5</i> Days <i>21</i>

10a. USUAL OCCUPATION (Give kind of work done during month preceding death, even if retired) <i>Child</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Caruthersville Mo</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13a. FATHER'S NAME <i>Billy Johnson</i>		13b. MOTHER'S MAIDEN NAME <i>Louis Hood</i>		14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Louis Hood</i> Address <i>Caruthersville RT 1</i>
---	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>atelectasis Right Lung + Bronchopneumonia</i>	
	DUE TO (c) <i>Possible aspiration of Foreign Body</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>9229</i>		19. WAS AUTOPSY PERFORMED? <i>2</i> 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.) <i>46</i>	
20c. TIME OF INJURY Hour a.m. p.m.	<i>078</i>	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 *11/29/57* to *12/1/57* and last saw <sup>her</sup>him alive on *12/1/57*  
Death occurred at *7 A* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Cecil E. Halcomb, M.D.</i>	22b. ADDRESS <i>Steele, Mo.</i>	22c. DATE SIGNED <i>12/2/57</i>
---	------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12-2-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion</i>	23d. LOCATION (City, town, or county) (State) <i>Steele Mo</i>
24. GENERAL DIRECTOR <i>German and Co.</i>	ADDRESS <i>Steele Mo</i>	25. DATE RECD. BY LOCAL REG. <i>12-14-57</i>	26. REGISTRAR'S SIGNATURE <i>John H. German</i>

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

12-280-57

DEC 19 1957

PEMISCOT COUNTY HEALTH DEPARTMENT  
COURTHOUSE PHONE 79  
CARUTHERSVILLE, MO.

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 Not Embalmed, Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. ....

P. O. Address .....

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.