

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2120

STATE FILE NUMBER

FILED FEB 10 1958

Registration District No. 239 Primary Registration District No. 4359 Registrar's No. 2

Health,
Welfare
Public
Service

300
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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Parma</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Parma</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last <u>Lynn</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>cauc.</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>Mar. 27 1872</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
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		11. BIRTHPLACE (City and state or country) <u>Crittenden County Ky.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Tom Lynn</u>		
14. MOTHER'S MAIDEN NAME <u>Vina Gann</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>500-16-6177</u>			17. INFORMANT <u>Nellie Lynn</u> Address <u>Parma 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>Cardiac decompensation</u>					INTERVAL BETWEEN ONSET AND DEATH
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)					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.) <u>4344</u>		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		20g. STATE	
21. I attended the deceased from <u>Jan. 19/58</u> to <u>Jan. 20/58</u> and last saw <u>him</u> alive on <u>Jan. 19/58</u> . Death occurred at <u>4:AM</u> on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE (Deceased or title) <u>Dr. Desh. W. Huates, M.D.</u>			22b. ADDRESS <u>Parma, Mo.</u>		22c. DATE SIGNED <u>1/21/58</u>
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b. DATE <u>Jan. 22 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Gillead Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Near Clarkton Mo.</u>
24. FUNERAL DIRECTOR <u>Watkins Fun. Service</u>		ADDRESS <u>Parma Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1/21/58</u>	26. REGISTRAR'S SIGNATURE <u>Dr. Desh. W. Huates, M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED JAN 29 1958
NEW MADRID CO. HEALTH CENTER

P. J. S.

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 Earl Metalkins.....

Licensed Embalmer No. 490

P. O. Address Dept. M

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.