

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019040

STATE FILE NUMBER

FILED MAY 20 1958

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 35

300  
-57

0774

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Miss.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Charleston</b> <u>0672</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>404 W. Cypress St.</b>		Length of stay in 1b <b>38 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>404 W. Cypress St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Woods</b> Last <b>Doty</b>			4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1958</b>	
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5. SEX <b>Female</b> <u>3</u>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> <b>Widowed</b>	8. DATE OF BIRTH <b>March 1, 1885</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Durant, Miss.</b> <u>1</u>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Unk.</b>	13b. MOTHER'S MAIDEN NAME <b>Janie (Unknown)</b>	14. NAME OF HUSBAND OR WIFE <b>Farris Doty</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Robert Williams, 404 W. Cypress, Charleston, Mo.</b>	Address
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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>Acute Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		<u>?</u>
	DUE TO (c) <u>Generalized Arteriosclerosis</u>		<u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>		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.)
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20c. TIME OF INJURY Hour <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	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
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21. I attended the deceased from <u>1 May 58</u> to <u>8 May 58</u> and last saw her <sup>her</sup> alive on <u>8 May 58</u> Death occurred at <u>11:30 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>John L. Sample M.D.</u>	22b. ADDRESS <u>Charleston Mo</u>	22c. DATE SIGNED <u>11 May 58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 12, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Charleston, Missouri</b>
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24. FUNERAL DIRECTOR <u>Mrs. F. J. Sparks</u>	ADDRESS <u>Charleston, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-15-58</u>	26. REGISTRAR'S SIGNATURE <u>Dorothy B. Hathorn</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

RECEIVED

Miss. Co. Health Dept

County File No. \_\_\_\_\_

Date Filed 5-19-58

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 Eddie Middleton

Licensed Embalmer No. 5046

P. O. Address 426 North St.

Cape Girardeau, 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.