

Health,  
& Welfare  
Public  
Service  
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THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

58-027949

STATE FILE NUMBER

FILED JUL 24 1958 Registration District No. 347 Primary Registration District No. 6159 Registrar's No. 52

1. PLACE OF DEATH a. COUNTY <b>Stone</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stone</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Blue Eye</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Blue Eye</b> <u>1646</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 <b>Blue Eye, Mo</b>		Length of stay in 1b <b>Years</b>	d. STREET ADDRESS (If outside, give location) <b>Blue Eye, Mo</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>TILLULAH JANE HERRING</b>			4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 Sept. 1865</b>	9. AGE (In years last birthday) <b>92</b> 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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kosciusko, Miss.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>William Black</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Boyt</b>		14. NAME OF HUSBAND OR WIFE <b>William Lee Herring</b>	
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>None</b>	17. INFORMANT Address <b>Mrs. F. M. Callen--Blue Eye Mo.</b>		
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><i>Pneumonia (Hypostatic)</i></u> DUE TO (b) <u><i>Organic heart</i></u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>48 hr</b>
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><i>May 25-58</i></u> to <u><i>June 24-58</i></u> and last saw her/him alive on <u><i>June 24-58</i></u> Death occurred at <u><i>2</i></u> or the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u><i>A. P. Carter</i></u>		22b. ADDRESS <u><i>Berryville, Ark.</i></u>		22c. DATE SIGNED <u><i>7-8-58</i></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-1-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Eye Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Blue Eye, Missouri</b>
24. FUNERAL DIRECTOR <b>Nelson Funeral Home-Berryville, Ark.</b>		25. DATE RECD. BY LOCAL REG. <u><i>July 18-58</i></u>		26. REGISTRAR'S SIGNATURE <u><i>Mrs. J. M. Brown</i></u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Occur, occur, 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)

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 *Charles M. Nelson* .....

Licensed Embalmer No. *5002* .....

P. O. Address *Benningville, 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.