

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029754  
STATE FILE NUMBER

Registration District No. 242 Primary Registration District No. 4362 Registrar's No. 17

300  
-57  
1

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>Mo</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marchaux</u>		c. CITY OR TOWN <u>Marchaux</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 <u>Home</u>		d. STREET ADDRESS (If outside, give location) <u>Home</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in 1b <u>25 years</u>			

3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>L.</u> Last <u>Kern</u>			4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</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>April 5, 1886</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>Eddyville, Ky.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Logan Forsythe</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Fowler</u>	14. NAME OF HUSBAND OR WIFE <u>Arthur Kern</u>
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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)	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT Address <u>Arthur Kern, Marchaux, Mo</u>
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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>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cachexia &amp; Malnutrition</u>	<u>4 mos.</u>
	DUE TO (c) <u>Cerebral Arteriosclerosis</u>	<u>334X 4 mos.</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PARKINSONISM AND SENILE DEMENTIA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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, Day, Year <u></u> a.m. <u></u> p.m. <u></u>
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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
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21. I attended the deceased from <u>February '58</u> to <u>AUGUST '58</u> and last saw her alive on <u>8/21/58</u> Death occurred at <u>9:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Declarant or title) <u>Ralph Franklin M.D.</u>	22b. ADDRESS <u>Marchaux, Mo.</u>	22c. DATE SIGNED <u>8-29-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried 8-25-1958</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Memories</u>	23d. LOCATION (City, town, or county) (State) <u>Likeston, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Albertton Funeral Home</u>	25. DATE RECD. BY LOCAL REG. <u>9-2-58</u>	26. REGISTRAR'S SIGNATURE <u>Kathryn L. Mc Bain</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DATE RECEIVED SEP 8 1958  
NEW MADRID CO. HEALTH CENTER  
P. J. Smith

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 Paul J. Smith .....

Licensed Embalmer No. 5015 .....

P. O. Address Oran, 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.