

FILED DEC 22 1958

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REG.#17659

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043363

STATE FILE NUMBER

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 690

300

-57

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>HOWELL</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>MOUNTAIN VIEW</b> <sup>6460</sup> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSPITAL</b>		Length of stay in 1b <b>3 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>ROUTE TWO</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLARENCE EDWARD DENTON</b>			4. DATE OF DEATH Month Day Year <b>DECEMBER 7, 1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-21-95</b>
9. AGE (In years last birthday) <b>63</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>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>	11. BIRTHPLACE (City and state or country) <b>MOUNTAIN VIEW, MISSOURI</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>ANDERSON DENTON</b>	
13b. MOTHER'S MAIDEN NAME <b>PEARL YARBER</b>		14. NAME OF HUSBAND OR WIFE <b>KATHERINE DENTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>VA HOSPITAL RECORDS, POPLAR BLUFF, 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) <b>PNEUMONITIS, BACTERIAL, RIGHT UPPER LOBE. <i>fav</i></b>			INTERVAL BETWEEN ONSET AND DEATH <b>Estimated one week.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>492X</b> <del>OTHER</del> <b>1. Arteriosclerotic Heart Disease (Class III)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>2. Arteriosclerotic Brain Disease, 3. Chronic Malnutrition, severe.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <input checked="" 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 <b>Dec. 4, 1958</b> to <b>Dec. 7, 1958</b> Death occurred at <b>9:20 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert S. Cohen</i> <b>ROBERT S. COHEN, M.D., Chief, Med. Svc.</b>		22b. ADDRESS <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>	22c. DATE SIGNED <b>12/8/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec 12, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mountain View</b>	23d. LOCATION (City, town, or county) (State) <b>Mountain View, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Frank-Cotrell Funeral Chapel Poplar Bluff, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12/13/58</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL diseases in Part I must be causally related.

1760

TO THE STATE BOARD OF HEALTH  
OF THE STATE OF MISSISSIPPI

FILE NO.

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
MEMPHIS, TENNESSEE

**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 E. Mungler

Licensed Embalmer No. 187  
P. O. Address Poplar Bluff

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.