

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5907
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58-045090

STATE FILE NUMBER

Dr. Bartlett

Registration District No. 272 Primary Registration District No. 5907 Registrar's No. 415

1. PLACE OF DEATH a. COUNTY <u>Remick</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Remick</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Stiles Coal Mine</u> Inside Limits <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Stiles</u> 0780 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Stiles</u> Length of stay in lb <u>20yr</u>		d. STREET ADDRESS (If outside, give location) <u>Route 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Pallie</u> Middle <u>Grant</u> Last			4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>58</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</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>2-13-1910</u>	9. AGE (In years last birthday) <u>48</u>	IF UNDER 1 YEAR Month <u>7</u> Days <u>16</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Work</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Camden Miss'</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Arthur Scott</u>	13b. MOTHER'S MAIDEN NAME <u>Bessie Adam</u>	13c. NAME OF HUSBAND OR WIFE <u>Johnnie Grant</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.	17. INFORMANT <u>Johnnie Grant</u> Address <u>Stiles Mo Rt 3</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>General Metastatic C.A.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>1955-1958</u>
DUE TO (b) <u>C.A. of Colon</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) <u>1538</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 _____ (Month, Day, Year) _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <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 <u>Stiles, Mo.</u>	COUNTY _____ STATE _____
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21. I attended the deceased from <u>Sept. 1958</u> to <u>Nov. 1958</u> and last saw her <u>alive</u> on <u>11/27/58</u> Death occurred at <u>10:35 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 (Double or title) <u>Robert Bartlett D.O.</u>	22b. ADDRESS <u>Stiles, Mo.</u>	22c. DATE SIGNED <u>1 Dec. 1958</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-27-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holly Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Stiles Mo</u>
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24. FUNERAL DIRECTOR <u>Berman Knut Co.</u>	ADDRESS <u>Stiles Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12/10/58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DEC 17 1930
COURT HOUSE
CARUTHERSVILLE, MO.

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 *Noel C. Sean*

Licensed Embalmer No. *3941*
P. O. Address *Caruthersville*

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.

interstate