Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000821
STATE FILE NUMBER

FILED JAN 21 1959 Registration District No. 103 Primary Registration District No. 40175 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY Dunklin b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hornersville — Inside Limits Yes [X] No [ ] c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION None — Length of stay in Ib	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dunklin c. CITY OR TOWN Hornersville — Inside Limits Yes [X] No [ ] d. STREET ADDRESS Hornersville (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First — Middle — Last: Ralph L. McElvain

4. DATE OF DEATH: Month Jan. Day 14 Year 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Jan-19-1893

9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months 11 Days 25 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Norris City Ill

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Jerimah McElvain

13b. MOTHER'S MAIDEN NAME: Margret Adams

14. NAME OF HUSBAND OR WIFE: Joe McElvain

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 252-56-1101

17. INFORMANT: Unknown — Address: Mrs. Joe McElvain Hornersville, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) arteriosclerotic cardiovascular disease — 10 years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4201

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 1/10/59 to 1/14/59 and last saw him alive on 1/14/59

Death occurred at 9:45 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R L Poberske (Degree or title) MD

22b. ADDRESS: Hornersville, Mo

22c. DATE SIGNED: 1/15/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 1-15-1959

23c. NAME OF CEMETERY OR CREMATORY: Little Prairie

23d. LOCATION (City, town, or county) (State): Caruthersville, Mo.

24. FUNERAL DIRECTOR — ADDRESS: LaForge Und. Co. C'ville Mo

25. DATE RECD. BY LOCAL REG.: 1/15/59

26. REGISTRAR'S SIGNATURE: Sue Palenske

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAR 5 1959

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 Joel C Grau

Licensed Embalmer No. 3941

P. O. Address Carrollton

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.