

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000824

STATE FILE NUMBER

FILED JAN 14 1959

Registration District No. 105 Primary Registration District No. 4177 Registrar's No. 1

300
-57

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clarkton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Clarkton</u> <u>350</u> Mile Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CLARKTON</u>		Length of stay in lb <u>LIFE</u>	d. STREET ADDRESS (If outside, give location) <u>CLARKTON</u> Reside on Form # Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>Sauls</u>			4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1881</u>	9. AGE (In years last birthday) <u>77</u>	10. FUNDER 1 YEAR Months <u>9</u> Days <u>15</u>	11. 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>Pensioner</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Dan Sauls</u>	13b. MOTHER'S MAIDEN NAME <u>Melisey Seaton</u>	14. NAME OF HUSBAND OR WIFE
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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) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Dan Sauls-Portageville, Mo.</u>	Address
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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>acute coronary insufficiency 2h,</u> <u>arteriosclerosis 15yr,</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>chronic cardiac insufficiency 2yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2h,</u> <u>15yr,</u> <u>2yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>

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 <u></u>	COUNTY <u></u>	STATE <u></u>
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21. I attended the deceased from <u>Sept, 1958</u> to <u>Jan 3 1959</u> and last saw her/him alive on <u>Jan 3-1959</u> , Death occurred at <u>on the date stated above; and to the best of my knowledge, from the causes stated.</u>
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22a. SIGNATURE <u>Z. S. Hopkins, M.D.</u> (Degree or title)	22b. ADDRESS <u>Gideon, Mo.</u>	22c. DATE SIGNED <u>1-7-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-6-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Park</u>	23d. LOCATION (City, town, or county) (State) <u>Near Lilbourn, Mo.</u>
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24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo</u>	ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>1-9-59</u>	26. REGISTRAR'S SIGNATURE <u>J. S. Schuman</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Harold J. Ponder*

Licensed Embalmer No. *5032*

P. O. Address *Silva, Me*

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.