

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012446

STATE FILE NUMBER

XC-122 98 01  
FILED APR 27 1959  
R#17813

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 195

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|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Butler</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Shannon</b>                  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Poplar Bluff</b>          |  | c. CITY OR TOWN <b>Eminence</b> <u>1010</u><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                            |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>VA Hospital</b> |  | d. STREET ADDRESS (If outside, give location) <b>General Delivery</b><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| Length of stay in lb <b>105 days</b>  |  |   |  |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>Verner</b> Middle <b>(none)</b> Last <b>Alcorn</b> |  |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>15</b> Year <b>1959</b> |  |  |
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| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>2-17-95</b> | 9. AGE (In years last birthday) <b>64</b> | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b> |
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| 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>Farming</b> | 11. BIRTHPLACE (City and state or country) <b>Iron County, Missouri</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
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| 13a. FATHER'S NAME <b>James Alcorn</b> | 13b. MOTHER'S MAIDEN NAME <b>Maggie Payne</b> | 14. NAME OF HUSBAND OR WIFE <b>Minnie Alcorn</b> |
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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) <b>yes WWI</b> | 16. SOCIAL SECURITY NO. <b>Unknown</b> | 17. INFORMANT Address <b>VA Hospital Records, Poplar Bluff, Mo.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY: <b>PERFORATION OF GASTRIC ULCER, SPONTANEOUS, WITH</b><br>IMMEDIATE CAUSE (a) <b>HEMORRHAGE INTRA-ABDOMINAL.</b> |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 Day.</b> |
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| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <b>PULMONARY EMPHYSEMA, CHRONIC.</b> | Unknown |
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| DUE TO (c) <b>BRONCHITIS, CHRONIC, BILATERAL.</b> | <b>50.20</b> | Unknown |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not used in the terminal diagnosis when stated in PART I):<br><b>1. THROMBOSIS, CHRONIC, RIGHT, FEMORAL ARTERY. 2. CHRONARY HEART DISEASE CHRONIC; SECONDARY POLYCYTHEMIA.</b> |  | 39. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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<br>Hour <b>VA</b> Month <b>12</b> Day <b>31</b> Year <b>58</b><br>a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | 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 <b>VA</b> COUNTY STATE |
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| 21. Attended the deceased from <b>12-31-58</b> to <b>4-15-59</b><br>Death occurred at <b>6:25p</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <b>J. Lester Harwell, M.D., Actg. Pathologist</b> (Degree or title) | 22b. ADDRESS <b>VA Hospital, Poplar Bluff, Mo.</b> | 22c. DATE SIGNED <b>4-16-59</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> | 23b. DATE <b>4-16-59</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Eminence Cem.</b> | 23d. LOCATION (City, town, or county) (State) <b>Eminence, Mo.</b> |
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| 24. FUNERAL DIRECTOR <b>Frank-Cotrell</b> ADDRESS <b>Poplar Bluff, Mo.</b> | 25. DATE RECD. BY LOCAL REG. <b>4/18/59</b> | 26. REGISTRAR'S SIGNATURE <b>[Signature]</b> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, or other person who certifies cause of death must be causally related. All diseases in Part I must be causally related.

MAY 28 1959

FILE NO.

MAY 26 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 *Charles E. Mungle* .....

Licensed Embalmer No. *4877* .....

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.