

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018591

STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 267 Primary Registration District No. 3049 Registrar's No. 73

1. PLACE OF DEATH a. COUNTY Pemiscot		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pemiscot	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hayti		c. CITY OR TOWN Hayti	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pemiscot County Mem.		d. STREET ADDRESS (If outside, give location) Route 1	
3. NAME OF DECEASED (Type or print) First Middle Last Cloyd Marion Handley		4. DATE OF DEATH Month Day Year May 9, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH January 15, 1918-41
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Manager	9b. KIND OF BUSINESS OR INDUSTRY Farming	9c. AGE (In years last birthday) 41	9d. IF UNDER 1 YEAR Months Days Hours Min.
10a. FATHER'S NAME Thomas Marion Handley		10b. MOTHER'S MAIDEN NAME Katie Leona Goodrum	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		12. SOCIAL SECURITY NO. 196 38 9167	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Arterio Sclerotic Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Acute Gastritis		14. NAME OF HUSBAND OR WIFE Nettie Mae Handley	
15. ACCIDENT SUICIDE HOMICIDE ☐ ☐ ☐		16. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
17. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		18. CITY, TOWN, OR LOCATION COUNTY STATE Caruthersville, Mo. 5-15-59	
19. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		20. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from 1952 to 1959 and last saw her alive on MAY 9, 1959 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) C. W. Mashke M.D.	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		24. DATE May 11, 1959	
25. NAME OF CEMETERY OR CREMATORY Maple Cemetery		26. LOCATION (City, town, or county) (State) Caruthersville, Missouri	
27. FUNERAL DIRECTOR H.S. Smith Funeral Home-C'ville. Mo.		28. DATE RECD. BY LOCAL REG. 5/11/59	
29. REGISTRAR'S SIGNATURE Valeria - Latham		30. DATE SIGNED 5-15-59	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. Cause of death must be stated in Part I. 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 *W. Dwyer Duke*

Licensed Embalmer No. *4484*
P. O. Address *Caruthersville, Mo.*

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.