

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018593

STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 267 Primary Registration District No. 3049 Registrar's No. 71

300
-57

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN PORTAGEVILLE
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION MEMORIAL HOSPITAL		Length of stay in 1b	0788 STREET ADDRESS ROUTE #2
3. NAME OF DECEASED (Type or print) First MATTIE Middle Last LEE			4. DATE OF DEATH MAY 2, 1959
5. SEX FEMALE	6. COLOR OR RACE 3 COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 2, 1932
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK	11. BIRTHPLACE (City and state or country) ARKANSAS
13a. FATHER'S NAME CHESTER CUNNINGHAM		13b. MOTHER'S MAIDEN NAME MAVADA EDWARD	14. NAME OF HUSBAND OR WIFE TIM LEE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Surgical Shock Stab wound Rt. Chest Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Stabbed by negro female in	
20c. TIME OF INJURY Hour a.m. (p.m.) Month, Day, Year May 2 1959		SA LOON AT Portageville	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, cctory, street, office bldg., etc.) SA LOON	20f. CITY, TOWN, OR LOCATION COUNTY STATE Portageville New Madrid Mo.
21. I attended the deceased from 3:00 PM 5/2/59 to 5 PM 5/2/59 and last saw him alive on 5/2/59 Death occurred at 5:15 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Shuchworth M.D.		22b. ADDRESS Hayti Mo.	22c. DATE SIGNED 5-15-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5-7-59	23c. NAME OF CEMETERY OR CREMATORY PORTAGEVILLE COLORED Cem.	23d. LOCATION (City, town, or county) (State) PORTAGEVILLE, Mo.
24. FUNERAL DIRECTOR DELISLE FUNERAL PALACE PORTAGEVILLE, Mo.		25. DATE RECD. BY LOCAL REG. 5/10/59	26. REGISTRAR'S SIGNATURE Valeria Popham

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 25 1959

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 *[Handwritten Signature]* Licensed Embalmer No. 4481

P. O. Address PORTAGEVILLE

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.