

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023436
STATE FILE NUMBER
2 5755

8
FILED JUL 1 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH -----
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **ST LOUIS** Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **ST LUKES HOSP** Length of stay in lb _____

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE **Arkansas** b. COUNTY **Maynard**
c. CITY OR TOWN **Maynard** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
FANNIE LEONA STINNETT **6-13-59**

5. SEX **FEMALE** 6. COLOR OR RACE **WHITE** 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH **9-6-1892** 9. AGE (In years last birthday) **66** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOUSEWIFE** 10b. KIND OF BUSINESS OR HOME **OWN HOME** 11. BIRTHPLACE (City and state or country) **ARKANSAS** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **JAMES NORRIS** 13b. MOTHER'S MAIDEN NAME **MAG GRAHAM** 14. NAME OF HUSBAND OR WIFE **ARTHUR STINNETT**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give year or dates of service) **NONE** 16. SOCIAL SECURITY NO. **UNKNOWN** 17. INFORMANT **ARTHUR STINNETT** Address **MAYNARD, ARKANSAS**

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 hepatic necrosis**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **Enter enterostomy** 19. WAS AUTOPSY PERFORMED? YES NO

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 **5-6-59** to **6-12-59** and last saw her alive on **6-12-59**
Death occurred at **5 a.m.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **Michael M. Karl, M.D.** (Degree or title) 22b. ADDRESS **4652 Maryland** 22c. DATE SIGNED **6-17-59**

23a. BURIAL, CREMATION, (Specify) **BURIAL** 23b. DATE **6-18-59** 23c. NAME OF CEMETERY OR CREMATORY **MASONIC CEMETERY** 23d. LOCATION (City, town, or county) (State) **POCAHONTAS, ARKANSAS**

24. FUNERAL DIRECTOR **M. C. MC NABB** ADDRESS **POCAHONTAS, ARK.** 25. DATE RECD. BY LOCAL REG. **JUN 17 '59** 26. REGISTRAR'S SIGNATURE **Paul Smith, M.D.**

5. 300
1-57
2
X
5
8
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Geulney R. Tol*.....

Licensed Embalmer No. *3481*.....
P. O. Address *Crystal City*.....

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.