

Health,
Welfare
Public
Service

300
1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Marvin Barber

FILED VS JUL 27 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-024311

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 528

1. PLACE OF DEATH a. COUNTY <u>Butler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Butler</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Harviell</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dr.'s Hospital</u>			Length of stay in 1b <u>1 yr.</u>	d. STREET ADDRESS Rt. 1 (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Lurena</u> Last <u>Halter</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 24, 1923</u>		9. AGE (In years - last birthday) <u>36</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		100. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Bert Myers</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Smith</u>			
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>Lawrence Halter, Harviell Mo.</u>			
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>Inter Medullary Hemorrhage</u> DUE TO (b) <u>Thrombocytopenic Purpura</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)							INTERVAL BETWEEN ONSET AND DEATH <u>Zero.</u>
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.) <u>296 X</u>				
20c. TIME OF INJURY Hour - Month, Day, Year a. m., p. m.							
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		COUNTY STATE	
21. I attended the deceased from <u>5-16</u> to <u>7-3-59</u> and last saw her alive on <u>7-3-59</u> Death occurred at <u>12:10</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Marvin R. Barber, M.D.</u>				22b. ADDRESS <u>Poplar Bluff Mo</u>		22c. DATE SIGNED <u>7/5/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE <u>July 5, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Poplar Bluff, Mo.</u>		
24. FUNERAL DIRECTOR <u>Irby Funeral Home Rector, Ark.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>7/18/59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

(Licensed Embolmer's Statement on Reverse Side)

JUL 24 1959
BUTLER CO. HEALTH CENTER
FILE No. _____

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 *Don McBride* _____

Licensed Embalmer No. *17* _____

P. O. Address *Butler Co.* _____

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.