

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024346

FILED VS JUL 1 1959

Primary Registration District No. 3

Registrar's No. 344

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY BUTLER				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY BUTLER					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FISK		Length of stay in 1b 5MO.		c. CITY OR TOWN FISK		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION IN FISK			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) FISK		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LAURA Middle BELL Last MOON				4. DATE OF DEATH Month JULY Day 1 Year 1959					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/19/19	9. AGE (last birthday) 40	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) CONRAN, MO.		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME ALTA GRAY			13b. MOTHER'S MAIDEN NAME FLORA FORTNER			14. NAME OF HUSBAND OR WIFE HERMAN MOON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address HERMAN MOON FISK, MO.				
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>Coronary occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Chronic valvular heart disease Congenital</u>							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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.)							
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year									
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>July 19 50</u> to <u>July 59</u> and last saw her alive on <u>22 June 59</u> Death occurred at <u>about 6:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Cynthia K. Post M.D.</u>				22b. ADDRESS <u>Poplar Bluff, Mo.</u>			22c. DATE SIGNED <u>3 July 59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 7-4-59	23c. NAME OF CEMETERY OR CREMATORY MOUNDS PARK		23d. LOCATION (City, town, or county) NEW MADRID MO.					
24. FUNERAL DIRECTOR ADDRESS WHITE'S FUNERAL HOME FISK, MO.			25. DATE RECD. BY LOCAL REG. 7/22/59		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Raymond L. Deffici

Licensed Embalmer No. 4798

P. O. Address Barni, T.

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.