

FILED VS AUG 7 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-024663

STATE FILE NUMBER

Registration District No. 105 Primary Registration District No. 4177 Registrar's No. 10

300
-57

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clarkton, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Clarkton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clarkton, Mo</u>		Length of stay in 1b <u>50 YRS.</u>	d. STREET ADDRESS (If outside, give location) <u>035^o NONE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Fertine</u> Last <u>Dunlap</u>			4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-1884</u>		9. AGE (In years at birthday) <u>74</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>16</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Beaufort, Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>William Prother</u>		13b. MOTHER'S MAIDEN NAME <u>Cynthia Burris</u>		14. NAME OF HUSBAND OR WIFE <u>deceased</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>no.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Ralph Horton - Clarkton, Mo.</u>	

18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Palmaray Edema</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Acute left Ventricular Heart Failure</u> DUE TO (c) <u>At least subacute Coarcted Vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>11 days</u> <u>unk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Lymphatic Leukemia</u> <u>4221H</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					

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, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>5-27-59</u> to <u>6-5-59</u> and last saw him alive on <u>6-5-59</u> Death occurred at <u>6:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Type or title) <u>Joseph Crowder M.D.</u>			22b. ADDRESS <u>Walden Mo</u>		22c. DATE SIGNED <u>6-8-59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-9-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stanfield</u>		23d. LOCATION (City, town, or county) (State) <u>Clarkton Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>McDaniel Funerals Service Kennett Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>6-10-59</u>	26. REGISTRAR'S SIGNATURE <u>J. D. Schuman</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *James L. Roberts*

Licensed Embalmer No. *4886*

P. O. Address *Kennett, 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.