

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026106

FILED VS JUL 20 1959

 Registration District No. 270 Primary Registration District No. 3050 Registrar's No. 45

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Pemiscott</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Caruthersville, Mo.</u>		Length of stay in lb <u>Life</u>		a. STATE <u>Missouri</u> COUNTY <u>Pemiscott</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Caruthersville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>rear of Johnson Goal</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. DATE OF DEATH		Month <u>July</u> Day <u>7</u> Year <u>1959</u>	
3. NAME OF DECEASED (Type or print) First <u>Claudett</u> Middle <u>Smith</u> Last <u>Smith</u>				4. DATE OF DEATH			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-27-58</u>	
9. AGE (last birthday) <u>11</u> Months <u>16</u> Days		IF UNDER 1 YEAR		IF UNDER 24 HR		Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Caruthersville, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Frank Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Annie Mae Cunningham</u>			14. NAME OF HUSBAND OR WIFE <u>None</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. <u>None</u>		17. INFORMANT <u>Frank Smith</u> Address <u>Caruthersville, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
IMMEDIATE CAUSE (a) <u>acute Colitis</u>							
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)						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>7-6-59</u> to <u>7-7-59</u> and last saw her/him alive on <u>7-6-59</u>				Death occurred at <u>9:45 AM.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>Caruthersville, Mo</u>		22c. DATE SIGNED <u>7-13-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 10 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Morgan Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Caruthersville, Mo.</u>	
24. FUNERAL DIRECTOR <u>LaForge Undertkg. Co. C'ville, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>July 16, 1959</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

