

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-028600

FILED VS SEP 15 1959

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 172

STATE FILE NUMBER

DEED

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>Kennett</u>		Length of stay in 1b		c. CITY OR TOWN <u>Kennett</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>Dunklin Memorial</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Carter St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Flora</u> Middle <u>Mac</u> Last <u>Dearing</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</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>11-6-1884</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>3</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR 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 <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Stodderlea-Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Iris Grant</u>			14. NAME OF HUSBAND OR WIFE <u>James M. Dearing-(dec)</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>Mrs. Imagehe Wallace-Kennett, Mo.</u>			Address			
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>arteriosclerotic heart dis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>yr.</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 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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>								
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>1956</u> to <u>8 Sept 59</u> and last saw <u>her</u> alive on <u>9-8-1959</u> Death occurred at <u>Approximately 8:10 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>Joe A. Zimmerman M.D.</u>				22b. ADDRESS <u>Kennett Mo.</u>				22c. DATE SIGNED <u>11 Sept 59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-10-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Kennett, Mo.</u>					
24. FUNERAL DIRECTOR <u>McDaniel Funeral Ser. Kennett, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>9-12-1959</u>		26. REGISTRAR'S SIGNATURE <u>Carl Hubbard</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 Tommy L. Roberts

Licensed Embalmer No. 4880

P. O. Address Kennett, U

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co  
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.