

Health, S. Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-028617

STATE FILE NUMBER

FILED VS AUG 26 1959

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 151

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Dunklin</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri New Madrid</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kennett</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Parma</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Dunklin County Memorial 3hrs.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>5 miles w. Parma</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED <b>Hospital</b> (Type or print) <b>Edward Robert Starnes</b>			4. DATE OF DEATH Month Day Year <b>July 23 1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3 1933</b>		9. AGE (In years if UNDER 1 YEAR; If UNDER 24 HRS. last birthday) Months Days Hours Min. <b>26</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farming</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Parma Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Oliver Starnes</b>		13b. MOTHER'S MAIDEN NAME <b>Ada Huffman</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Oliver Starnes Parma Mo Rt. 2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing injury chest</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 Hrs</b>
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)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <b>Automobile accident</b>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			<b>Tracheostomy done</b>		
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, factory, street, office bldg., etc.) <b>Highway</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Dunklin Mo.</b>	
21. I attended the deceased from <b>1:15 PM - 7-23-59</b> , to <b>7-23-59</b> and last saw her/him alive on <b>7-23-59</b> Death occurred at <b>1:00 am</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Paul C. Miltenberger M.D.</b>			22b. ADDRESS <b>Kennett, Mo.</b>		22c. DATE SIGNED <b>8-13-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>July 25, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Gilead</b>		23d. LOCATION (City, town, or county) (State) <b>South of Malden Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Watkins Funeral Services Parma Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>8-17-1959</b>		26. REGISTRAR'S SIGNATURE <b>Paul Huffman</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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DEPARTMENT ..... 8-24-59 .....  
COUNTY FILE NUMBER 857-255

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 *Carl Matthews* .....

Licensed Embalmer No. 4964 .....  
P. O. Address Denver, 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.