

FILED VS AUG 26 1959

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

59-028624

STATE FILE NUMBER 33

Registration District No. 109 Primary Registration District No. 418D Registrar's No.

V. S. 300  
 Rev. 1-57

securing the medical certification in the specific manner required by 193.140 MOARS 1957.  
 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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Dunklin</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Arkansas</b> b. COUNTY <b>Clay</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Campbell, Mo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Rector</b>
c. FULL NAME OF (If NOT in hospital, give location) INSTITUTION <b>Baptist Nursing Home</b>		Length of stay in lb <b>6 mo</b>	d. STREET ADDRESS - <b>0-</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Golden</b> Last <b>Golden</b>			4. DATE OF DEATH Month <b>8</b> - Day <b>15</b> - Year <b>1959</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-10-1890</b>
9. AGE (In years at birthday) <b>69</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>5</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Mississippi</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13a. FATHER'S NAME <b>Unknown</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>-0-</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>-0-</b>	17. INFORMANT Address <b>O.H. Allison, Rector, Ark</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>Carcinomatosis secondary to a probable carcinoma of the colon.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7</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) <b>1538</b>			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 _____ o.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 <b>11/11/58</b> to <b>8/12/59</b> and last saw <sup>her</sup> him alive on <b>8/12/59</b> Death occurred at <b>5:30 p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Wallace Belsey M.D.</b>		22b. ADDRESS <b>Campbell - Mo.</b>	22c. DATE SIGNED <b>8/22/59</b>
23a. BURIAL, CREMATION, etc. (Specify) <b>Burial</b>	23b. DATE <b>8-16-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodland Hgts Cem</b>	23d. LOCATION (City, town, or country) <b>Rector, Ark</b> (State)
24. FUNERAL DIRECTOR <b>Mitchell Funeral Home, Rector, Ark</b>		25. DATE RECD. BY LOCAL REG. <b>8-22-1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs Beulah Campbell</b>

DEPARTMENT ..... 8-24-59 .....  
COUNTY FILE NUMBER ... 852-2581

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 *Randall R. Mitchell*

Licensed Embalmer No. *373-anc*  
P. O. Address *Paragould*

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.

SEP 9 - 1959