

# MICHIGAN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029927

FILED VS SEP 14 1959

Registration District No. 264 Primary Registration District No. \_\_\_\_\_ Registrar's No. 41 STATE FILE NUMBER

|   |  |   |  |  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Ozark</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY _____ |  |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Big Creek</u>  |  |   | Length of stay in 1b _____   |  | c. CITY OR TOWN <u>Protem</u>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hiway 160</u>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                             |  | d. STREET ADDRESS (If outside, give location) <u>CRUAL</u>   |   | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>James Eddie Lound</u>   |  |   |  | 4. DATE OF DEATH Month Day Year<br><u>9-5-59</u>   |  |   |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>5-15-42</u>  | 9. AGE (last birthday) <u>17</u>   | IF UNDER 1 YEAR<br>Months _____ Days _____                                    | IF UNDER 24 HR<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>School boy</u>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY _____  |  | 11. BIRTHPLACE (City and state or country) <u>Peel, Arkansas</u>   |   | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>   |
| 13a. FATHER'S NAME <u>Jim Ford</u>  |  |   | 13b. MOTHER'S MAIDEN NAME <u>Raggie Lound</u>  |  |  | 14. NAME OF HUSBAND OR WIFE _____   |   |
| 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 Address<br><u>Ed Lound, Protem, Mo.</u>  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Skull Fracture</u><br>DUE TO (b) <u>Fractures of legs left Arm</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hrs.</u>                                     |
| 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.<br><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 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.)<br><u>CAR WRECK</u> |  |  |   |   |
| 20c. TIME OF INJURY Hour Month, Day, Year<br><u>2:15 p.m. 9-5-59</u>  |  | 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.)<br><u>Hiway 160</u>                 |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE<br><u>Big Creek Twp. Ozark, Mo.</u> |   |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at <u>4:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |  |  |   |   |
| 22a. SIGNATURE (Degree or title)<br><u>John R. Huey Curran</u>  |  |   |  | 22b. ADDRESS<br><u>Earleville Mo.</u>  |  |   | 22c. DATE SIGNED<br><u>9-7-59</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>9-8-59</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Wolf</u>  |  | 23d. LOCATION (City, town, or county) (State)<br><u>Taney Co. Mo.</u>  |   |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Glinkingbeard, Guinesville, Mo</u>   |  |   | 25. DATE RECD. BY LOCAL REG.<br><u>9-12-59</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Shane Mahan</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 John R. Carey

Licensed Embalmer No. 4885

P. O. Address Camden

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.