

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031592

FILED VS. SEP 25 1959 REG. NO. A-1316

Registration District No. Primary Registration District No. 3007 Registrar's No. 433

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ARKANSAS</b> COUNTY <b>GREENE</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>3 DAYS</b>	c. CITY OR TOWN <b>PARAGOULD</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>VETERANS ADM. HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>ROUTE FOUR</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROLLEN</b> Middle <b>(NONE)</b> Last <b>BOONE</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/25/20</b>	9. AGE (last birthday) <b>38</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICEMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LAW ENFORCEMENT</b>	11. BIRTHPLACE (City and state or country) <b>PIGGOTT, ARKANSAS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOSEPH D. BOONE</b>		13b. MOTHER'S MAIDEN NAME <b>MARTHA L. LUSK</b>		14. NAME OF HUSBAND OR WIFE <b>GLENDA BOONE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</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>MYOCARDIAL INFARCTION.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 Weeks</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)				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 _____ 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. attended the deceased from <b>Sept. 9, 1959</b> to <b>Sept. 12, 1959</b> Death occurred at <b>5:15 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Robert S. Cohen</i> <b>ROBERT S. COHEN, M.D., Chief, Medical Svc.</b>			22b. ADDRESS <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>		22c. DATE SIGNED <b>9/16/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>9-14-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Linwood</b>		23d. LOCATION (City, town, or county) (State) <b>Paragould, Arkansas</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell Funeral Home Paragould, Arkansas</b>		25. DATE RECD. BY LOCAL REG. <b>9/18/59</b>		26. REGISTRAR'S SIGNATURE <i>R. Mitchell</i>		

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 Richard M Mitchell

Licensed Embalmer No. 703  
P.O. Address Paragon

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.