

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031906

FILED VS SEP 23 1959

STATE FILE NUMBER

Registration District No. 109 Primary Registration District No. 418D Registrar's No. 39

1. PLACE OF DEATH a. COUNTY <u>General Baptist Dist</u> <u>Hann Campbell MO.</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>Campbell MO.</u>		Length of stay in 1b <u>4 MO.</u>	c. CITY OR TOWN <u>Kennett</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Baptist Dist</u> <u>Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1701 Russell St</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRIETT AIRBelle STARNES</u>		4. DATE OF DEATH Month Day Year <u>8-26-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/29/1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired housewife Hann Mo.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>all</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>95</u> Months <u>10</u> Days <u>27</u> Hours Min.
11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Dale Young</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>W.F. Starnes</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Hershel Williams</u> Address <u>Kennett MO</u>

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>Acute Cardiac Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Auricular Fibrillation &amp; mitral regurgulation</u>		<u>7 years</u>
DUE TO (c) <u>Arteriosclerotic C. V. Disease</u>		<u>?</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. <input type="checkbox"/> Yes <input checked="" 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 Month, Day, Year a.m. p.m.		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>7/28/59</u> to <u>8/23/59</u> and last saw her/him alive on <u>8/23/59</u> Death occurred at <u>2:45 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wallace Belsey M.D.</u>		22b. ADDRESS <u>Campbell Mo.</u>	22c. DATE SIGNED <u>9/18/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/27/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge</u>	23d. LOCATION (City, town, county) (State) <u>Kennett MO</u>
24. FUNERAL DIRECTOR <u>W. E. Emmons</u>		25. DATE RECD. BY LOCAL REG. <u>9-18-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Dulah Campbell</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 Mr. T. E. Egan

Licensed Embalmer No. 352

P. O. Address Forrest

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.