

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032154

FILED VS. SEP 21 1959/4/

Registration District No. _____ Primary Registration District No. 3025 Registrar's No. 120

STATE FILE NUMBER

IDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY Howell		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN West Plains		Length of stay in lb 11 hr 20min		c. CITY OR TOWN Koshkonong		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION West Plains Mem. Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Charles Middle Stephens Last MCCoach				4. DATE OF DEATH Month September Day 6 , Year 1959				
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-6-1959		
9. AGE (last birthday)		IF UNDER 1 YEAR Months		IF UNDER 24 HR Days		11 20 in.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) West Plains, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Charles McCoach			13b. MOTHER'S MAIDEN NAME Carolyn L. Blevins			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)			16. SOCIAL SECURITY NO.		17. INFORMANT Charles McCoach, Koshkonong, Mo Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Kernicterus							birth	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Elevated serum bilirubin							"	
DUE TO (c) Infections hepatitis of mother							5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary atelectasis						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 checked="" 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 9/6/59 to 9/6/59 and last saw her/him alive on 9/6/59 . Death occurred at 6 p m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) M-L Souler MD				22b. ADDRESS West Plains Mo		22c. DATE SIGNED 9/11/59		
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 8-8-1959		23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		23d. LOCATION (City, town, or county) (State) Oxford, Arkansas		
24. FUNERAL DIRECTOR Lealand Carter, West Plains Mo ADDRESS			25. DATE RECD. BY LOCAL REG. 9-17-59		26. REGISTRAR'S SIGNATURE Beatrice Cook			

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 Douglas P. Garman

Licensed Embalmer No. 5037

P. O. Address West Hall

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.