

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036978

FILED VS OCT 26 1959

STATE FILE NUMBER

Registration District No. 239 Primary Registration District No. 4356 Registrar's No. 18

INDEXED

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Parma</u>		Length of stay in 1b <u>30 yrs</u>		c. CITY OR TOWN <u>Parma</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input 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 <u>Alfonzo</u> Middle <u>Avant</u> Last <u>Avant</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>3</u> Year <u>1959</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1900</u>	9. AGE (last birthday) <u>58 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>railroad worker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Enid, Miss.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Dan Avant</u>			13b. MOTHER'S MAIDEN NAME <u>Lula Brown</u>			14. NAME OF HUSBAND OR WIFE <u>deceased</u>			
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>333-12-3696</u>		17. INFORMANT <u>Mrs. Lula Battles, Parma, Mo.</u>				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) <u>CARDIAC DEGENERATION</u>							<u>WEEKS.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARCINOMA - LEFT LUNG</u>							<u>WEEKS</u>		
DUE TO (c) <u>GENERAL DEBILITY</u>							<u>WEEKS</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 type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u> </u> a.m. <u> </u> p.m. <u> </u>			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 <u>SEPT 18-59</u> to <u>OCT 3-59</u> and last saw her <u>SEPT 18-59</u> Death occurred at <u>4: P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>L. J. Lang, MD</u> (Deceased or this)				22b. ADDRESS <u>MALDEN - MISSOURI</u>			22c. DATE SIGNED <u>10-10-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Oct. 6 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catron</u>		23d. LOCATION (City, town, or county) <u>N. of Catron Mo.</u>			(State)	
24. FUNERAL DIRECTOR <u>Watkins Funeral Service</u> ADDRESS <u>Parma Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>10/14/59</u>		26. REGISTRAR'S SIGNATURE <u>L. J. Lang, MD</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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Marsh W. Wilkins

Licensed Embalmer No. 4717

P. O. Address Septon

-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.