

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039547

FILED VS NOV 25 1959

Registration District No. 109 Primary Registration District No. 5424 Registrar's No. 47

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY Dunklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ark. b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural-Union Twp.		Length of stay in 1b 1 day	c. CITY OR TOWN Corning Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Campbell, Rte. 3		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 703 First Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First VICKI Middle LYNN Last WALKER			4. DATE OF DEATH Month November Day 20 Year 1959		
---	--	--	--	--	--

5. SEX Female	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 Sept. 28, 1959	9. AGE (last birthday) 1 Months 22 Days	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	---	--	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Corning, Arkansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	-----------------------------------	--	--

13a. FATHER'S NAME Bill Walker	13b. MOTHER'S MAIDEN NAME Wanda Beecher	14. NAME OF HUSBAND OR WIFE None
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Bill Walker, Corning, Arkansas	Address
---	--	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia		INTERVAL BETWEEN ONSET AND DEATH Unknown
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 Kennett, Mo.	COUNTY Clay	STATE Ark.
---	--	--	---	-----------------------	----------------------

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at **4 A.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Quinton Tarver (Degree or title) Quinton Tarver, M.D., Surgeon	22b. ADDRESS Kennett, Mo.	22c. DATE SIGNED 11-20-59
---	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 21, 1959	23c. NAME OF CEMETERY OR CREMATORY Post Oak Cemetery	23d. LOCATION (City, town, or county) (State) McDougal, Arkansas
--	-----------------------------------	--	--

24. FUNERAL DIRECTOR Landess Funeral Home, Campbell, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 11-21-59	26. REGISTRAR'S SIGNATURE Mrs. Beulah Campbell
--	---------	---	--

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 Christine M. Landers

Licensed Embalmer No. 422
P. O. Address Campbell

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.