

FEDERAL BUREAU OF INVESTIGATION
FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 4 6 6

FILED 1959 JAN 1 1960

REG. NO. AT 391

Primary Registration District No. 3007

Registrar's No. 6215

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY BUTLER				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY LAWRENCE					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 35 DAYS		c. CITY OR TOWN HOXIE		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) ROUTE ONE		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last MURPHY "Z" CUDE				4. DATE OF DEATH Month Day Year DECEMBER 21, 1959					
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1-13-05	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (City and state or country) BIRDELL, ARKANSAS		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME JOHN W. CUDE			13b. MOTHER'S MAIDEN NAME MAE DUNN			14. NAME OF HUSBAND OR WIFE INEZ CUDE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWII			16. SOCIAL SECURITY NO. 432483139		17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE.							INTERVAL BETWEEN ONSET AND DEATH 7 Years.		
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 Nov. 16, 1959 to Dec. 21, 1959 and last saw her/him alive on _____ Death occurred at 8:14 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Robert S. Cohen</i> ROBERT S. COHEN, M.D., Chief, Medical Svc.				22b. ADDRESS VA Hospital, Poplar Bluff, Mo.				22c. DATE SIGNED 12/21/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec 23, 1959	23c. NAME OF CEMETERY OR CREMATORY Oak Forrest Cemetery		23d. LOCATION (City, town, or county) (State) Black Rock, Arkansas.				
24. FUNERAL DIRECTOR Bryan Funeral Home			ADDRESS Hoxie, Ark.		25. DATE RECD. BY LOCAL REG. 12/28/59		26. REGISTRAR'S SIGNATURE <i>R. H. Muehler</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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert F. Warden
Robert F. Warden

Ark. Licensed Embalmer No. 1110

P. O. Address Hoxie, Arkansas

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.