

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 4 7 3

RN: A-1574

43

3007

6008

STATE FILE NUMBER

ENDED

FILED VS JAN - 4 1960

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY CLAY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in lb 47 days	c. CITY OR TOWN CORNING
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 301 East 2nd Street
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First RAYMOND Middle (NMN) Last ESTILL			4. DATE OF DEATH Month December Day 10 Year 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 9-19-99	9. AGE (last birthday) 60	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTAL DEPARTMENT	10b. KIND OF BUSINESS OR INDUSTRY MAIL CARRIER	11. BIRTHPLACE (City and state or country) FAYETTE, MISSOURI	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME JAMES ESTILL		13b. MOTHER'S MAIDEN NAME LULA CLOYD	
14. NAME OF HUSBAND OR WIFE MAMIE ESTILL			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIABETES MELLITUS WITH GANGRENE OF LEFT FOOT.		INTERVAL BETWEEN ONSET AND DEATH 15 Years & 45 days respect.
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. I attended the deceased from **October 24, 1959** to **December 10, 1959** and **VA** Death occurred at **9:15 PM** 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, Med. Svc.	22b. ADDRESS VAH POPLAR BLUFF, MO.	22c. DATE SIGNED 12-11-59
--	---	--

23a. BURIAL, CREMATION, REMOVAL (Specify) Furial	23b. DATE Dec. 13, 1959	23c. NAME OF CEMETERY OR CREMATORY Corning	23d. LOCATION (City, town, or county) (State) Corning, Ark.
---	--	---	--

24. FUNERAL DIRECTOR Russell-Ermert, Corning, Ark.	25. DATE RECD. BY LOCAL REG. 12/21/59	26. REGISTRAR'S SIGNATURE <i>R. M. ...</i>
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 4 1960

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 Leshie D. Russell

Licensed Embalmer No. 3855

P. O. Address Cornwall, Ark

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.