

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS JAN - 5 1960 239

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STATE FILE NUMBER

Registration District No. 239 Primary Registration District No. 5825 Registrar's No. 22

ENDED

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Parma (Como twp)</u>		Length of stay in 1b	c. CITY OR TOWN <u>Parma</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 mi.S of Parma</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 mi.S of Parma</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>Oliver</u> Last <u>Thomas</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20 1915</u>	9. AGE (last birthday) <u>44yrs</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Hernanda Miss.</u>	
10c. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Willie Oliver</u>		13b. MOTHER'S MAIDEN NAME <u>Ada Stagough</u>	
13c. NAME OF HUSBAND OR WIFE <u>Charley Thomas</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>none</u>	
17. INFORMANT <u>Charley Thomas, Parma Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>from history Cardiac decompensation</u> IMMEDIATE CAUSE (a) DUE TO (b) <u>Unknown dead when I arrived</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
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 <u>7:00</u> 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 <u>7:00 A.M.</u> <u>Dead when I arrived</u> <u>her</u> <u>last</u> saw <u>him</u> alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Dr. Geo. Husted, M.D.</u>			22b. ADDRESS <u>Parma, Mo.</u>		22c. DATE SIGNED <u>12/19/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Dec. 20, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catron Colored</u>		23d. LOCATION (City, town, or county) <u>3 Mi. N. of Catron Mo.</u>
24. FUNERAL DIRECTOR <u>Watkins Funeral Service</u> <u>Parma MO</u>		25. DATE RECD. BY LOCAL REG. <u>12/19/59</u>		26. REGISTRAR'S SIGNATURE <u>Dr. Geo. Husted, M.D.</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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Mark Walthers*

Licensed Embalmer No. 4717

P. O. Address Dexter W.

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.