

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS JAN 13 1960 267

Registration District No. 267 Primary Registration District No. 3049 Registrar's No. 173

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>Pemiscot</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hayti</u> Length of stay in lb <u>6 Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pemiscot County Hsp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pemiscot</u> c. CITY OR TOWN <u>Caruthersville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>712 E. 9th. St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Warren</u> Middle <u>Edgar</u> Last <u>Dearing</u>			4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>3/6/86</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Wynn, Arkansas</u>			
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Benjamin Franklin Dearing</u>		13b. MOTHER'S MAIDEN NAME <u>Louisa Hill</u>			
14. NAME OF HUSBAND OR WIFE <u>X</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 Address <u>304 E 7th. St</u> <u>Ruby Parkinson-Caruthersville, Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C. V. A.</u> DUE TO (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
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			
20g. STATE		21. I attended the deceased from <u>Dec. 12, 1959</u> to <u>Dec. 19, 1959</u> and last saw him alive on <u>Dec. 19, 1959</u> Death occurred at <u>12:25 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>C. W. Mckeeble M.D.</u>			22b. ADDRESS <u>Caruthersville, Mo.</u>		22c. DATE SIGNED <u>12-24-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Dec. 19, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dearing Cemetery</u>			
23d. LOCATION (City, town, or county) <u>Wynn, Arkansas</u>		23e. STATE					
24. FUNERAL DIRECTOR <u>H.S. Smith Funeral Home-C'ville. Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12-24-59</u>		26. REGISTRAR'S SIGNATURE <u>L. J. Adams</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 W. Dewey Pike

Licensed Embalmer No. 4484

P. O. Address Caruthersville

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.