

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 3 0 7

FILED VS DEC 21 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **211424**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pemiscot					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 35 days		c. CITY OR TOWN Hayti		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 106 East Main Street.,			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Elnor Cecil			4. DATE OF DEATH Month Day Year December 5, 1959						
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/3/1915	9. AGE (last birthday) 44	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Caruthersville, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.			
13a. FATHER'S NAME Joseph R. Cecil			13b. MOTHER'S MAIDEN NAME Flora Betcher			14. NAME OF HUSBAND OR WIFE Darlene Cecil			
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. 196-38-9953		17. INFORMANT Address Ronnie Cecil, Hayti, 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) Hepatic coma & bleeding esophageal varices Hepatic Coma and Bleeding Esophageal Varices Laennec's cirrhosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Laennec's Cirrhosis DUE TO (b) 581-1 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 24 hrs 2 yrs		
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, Month, Day, Year a.m. p.m.			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 Nov 12 1959 to Dec 5, 1959 and last saw him ^{her} alive on Dec 4, 1959 Death occurred at 9:15 P.M. 9:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							22c. DATE SIGNED 12/7/59		
22a. SIGNATURE (Deceased or title) Rudolph E. Catanzaro, M.D.			22b. ADDRESS 1194 Hodiament, Louis 1194 Hodiament			22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-6-59	23c. NAME OF CEMETERY OR CREMATORY Maple Cemetery		23d. LOCATION (City, town, or county) Caruthersville, Mo.		(State)		
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.			ADDRESS	25. DATE RECD. BY LOCAL REG. DEC 9 1959	26. REGISTRAR'S SIGNATURE Karl Smith, M.D.				

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 30 1950

St. Louis
Resour. Bst. Hospital

Joseph L. Cecil
Darlene Cecil
Ronnie Cecil, Hattie, No.

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

by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Elton P. Penelick

Licensed Embalmer No. 4283

P. O. Address St. Louis

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.
