

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000445

FILED VS JAN 29 1960
 XC-1209567

REG. NO. 43
 LA-1815

Registration District No. _____ Primary Registration District No. 3007 Registrar's No. 39 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CAPE GIRARDEAU	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 27 DAYS	c. CITY OR TOWN JACKSON
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 TWO
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First AUGUST	Middle LOUIS	Last BEST	4. DATE OF DEATH Month JANUARY Day 9, Year 1960
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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 6-4-87	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN	10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) CAPE GIRARDEAU, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME FRED BEST	13b. MOTHER'S MAIDEN NAME FREDERICKA BUTTMAN	14. NAME OF HUSBAND OR WIFE LENA BEST
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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 MRS. LENA BEST, RTE. 2, JACKSON, MO.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA.	INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
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) 1. GENERALIZED ARTERIOSCLEROSIS.	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year
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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 VA	COUNTY	STATE
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21. I attended the deceased from **DECEMBER 13, 1959** to **JANUARY 9, 1960** and last saw her _____ her death occurred at **1:45 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE B. M. GARDNER, M.D., Actg. Chief, Surg. Svc. VA HOSPITAL, POPLAR BLUFF, MO.	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED 1/13/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 11, 1960	23c. NAME OF CEMETERY OR CREMATORY Tilsit Cemetary	23d. LOCATION (City, town, or county) (State) Jackson Mo R#2
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24. FUNERAL DIRECTOR McCombs	ADDRESS Jackson, Mo.	25. DATE RECD. BY LOCAL REG. 1/20/60	26. REGISTRAR'S SIGNATURE [Signature]
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.