

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 8 1960

60-000447

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 62

1. PLACE OF DEATH a. COUNTY <b>Butler</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Stoddard</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>		Length of stay in lb <b>9 days</b>		c. CITY OR TOWN <b>Dexter</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Poplar Bluff Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>108 S. Park St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Angeline</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1960</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-2-92</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (City and state or country) <b>Dexter, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Jess Cunningham</b>			13b. MOTHER'S MAIDEN NAME <b>Eveline Hill</b>			14. NAME OF HUSBAND OR WIFE <b>deceased</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b> <input checked="" type="checkbox"/>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Delphia Oliver</b> Address <b>Dexter, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>?</b>		
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 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 <b>4 Jan 60</b> to <b>13 Jan 60</b> and last saw her <b>big</b> alive on <b>13 Jan 60</b> . Death occurred at <b>7:15 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Art Brooks MD</b> (Degree or title)				22b. ADDRESS <b>321 Oak Poplar Bluff, Mo.</b>			22c. DATE SIGNED <b>22 Jan 60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>1-16-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Malden, Mo</b>			
24. FUNERAL DIRECTOR <b>Watkins &amp; Sons</b> ADDRESS <b>Dexter, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>1/30/60</b>		26. REGISTRAR'S SIGNATURE <b>R. M. Muehr</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 28 1960

**STATEMENT BY LICENSED EMBALMER  
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I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
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. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.  
working under my personal supervision.

Student \_\_\_\_\_  
Student \_\_\_\_\_  
Signature of Student Embalmer  
Signature of Student Embalmer

Signed Mark Watkins  
Signed \_\_\_\_\_

Licensed Embalmer No. 4717  
Licensed Embalmer No. \_\_\_\_\_  
P. O. Address Dexter  
P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co  
with the above constitutes grounds for revocation of license.  
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with the above constitutes grounds for revocation of license.  
If embalmed by STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.