

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000448

DED

Registration District No. XC-14341964/3 REG. NO. A1994 Primary Registration District No. 3007 Registrar's No. 54

STATE FILE NUMBER

FILED VS FEB 8 1960

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ARKANSAS</b> b. COUNTY <b>CLAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>2 DAYS</b>	c. CITY OR TOWN <b>GREENWAY</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>VETERANS ADM. HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>NONE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLARD</b> Middle <b>ALLEN</b> Last <b>CHUCK</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>20</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-92</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT &amp; FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STORE &amp; AGRICULTURE</b>	11. BIRTHPLACE (City and state or country) <b>McLEANSBORO, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>GEORGE W. CLUCK</b>		13b. MOTHER'S MAIDEN NAME <b>CASANDER WILLIS</b>		14. NAME OF HUSBAND OR WIFE <b>BLANCHE L. CLUCK</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>BLANCHE L. CLUCK, GREENWAY, ARK. (WIFE)</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>		<b>36 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Arteriosclerosis</b>	<b>Unknown</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 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 STATE

21. **VA** attended the deceased from **JANUARY 18, 1960** to **JAN. 20, 1960** and last saw her alive on \_\_\_\_\_  
Death occurred at **6:25 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Robert S. Cohen</b> <b>ROBERT S. COHEN, M.D., Chief, Medical Svc. VA HOSPITAL, POPLAR BLUFF, MO.</b>	22b. ADDRESS <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>	22c. DATE SIGNED <b>1/22/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-22-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mitchell</b>
23d. LOCATION (City, town, or county) (State) <b>Greenway, Arkansas</b>		

24. FUNERAL DIRECTOR <b>Russell Mortuary Piggott, Ark</b>	25. DATE RECD. BY LOCAL REG. <b>1/27/60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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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 ME Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Gerald W. Boyer and

Licensed Embalmer No. 1116

P. O. Address Dayton, OH

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.