

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS FEB 5 1960

-60-002624

Registration District No. 238 Primary Registration District No. 5823 Registrar's No. 49

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>New Madrid Twsp</u>		Length of stay in lb <u>2 years</u>		c. CITY OR TOWN <u>New Madrid</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 mile E. of Lilbourn,</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>L.</u> Middle <u>C.</u> Last <u>Clark</u>				4. DATE OF DEATH Month <u>January</u> Day <u>19.</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 27, 1919</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>22</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>		
13a. FATHER'S NAME <u>Nelson Clark</u>			13b. MOTHER'S MAIDEN NAME <u>Alberta Woods</u>			14. NAME OF HUSBAND OR WIFE <u>Airlee Clark</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.		17. INFORMANT <u>Airlee Clark-Route 1 New Madrid, Mo.</u>			Address	
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>Septicemia -</u> <u>Decubitus</u> { <u>both hips and Sacral</u> } DUE TO (b) <u>area -</u> DUE TO (c) <u>Gunshot wound - Paralysis</u> { <u>lower half</u> } <u>of body &amp; legs</u>							INTERVAL BETWEEN ONSET AND DEATH		
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 <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>8-4-1956</u> to <u>Jan 19-1960</u> and last saw <sup>him</sup> <u>him</u> alive on <u>Jan 17-1960</u> . Death occurred at <u>1:00 A.</u> <u></u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>O.B. Chandler M.D.</u>				22b. ADDRESS <u>New Madrid Mo</u>				22c. DATE SIGNED <u>1-25-60.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-24-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sand Hill</u>			23d. LOCATION (City, town, or county) (State) <u>New Madrid, Mo</u>			
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-26-60</u>		26. REGISTRAR'S SIGNATURE <u>Jay Hedgsetts</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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Edward H. Ponder

Licensed Embalmer No. 5030  
P. O. Address Lithonia,

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.

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