

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**TITLED VS JAN 2 8 1960**

**-60-002632**

Registration District No. 239 Primary Registration District No. 239 Registrar's No. 2

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Catron Rt 1</u>		Length of stay in 1b <u>6 hrs</u>	c. CITY OR TOWN <u>Catron Rt 1</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		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4 miles SW of Catron</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Zackie</u> Middle <u>Dan</u> Last <u>Squires</u>			4. DATE OF DEATH <u>Jan. 1, 1960</u> Month Day Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>cauc.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31 1960</u>	9. AGE (last birthday)	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nil</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Catron Mo Rt 1</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jack Squires</u>		13b. MOTHER'S MAIDEN NAME <u>Velma Powell</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Jack Squires</u> Address <u>Catron Mo Rt 1</u>		

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>Umbilical Cord hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hr</u>
DUE TO (b) <u>Inadequate Ligation of Cord.</u>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Plasma therapy</u>					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. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>3:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Haynesbrook MD.</u> (Degree or title)			22b. ADDRESS <u>Malden Mo.</u>		22c. DATE SIGNED <u>1-5-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>Jan. 1, 1960</u>	<u>Taylor Cemetery</u>		<u>3 Mi S of Essex Mo</u>	
24. FUNERAL DIRECTOR <u>Watkins &amp; Son</u> ADDRESS <u>Parma Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1/8/60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. J. W. Thustet, MD.</u>	

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

*Not Embalmed*

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 do so 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.

