

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002704

Registration District No. 270 Primary Registration District No. 3050 Registrar's No. 5 STATE FILE NUMBER

MAILED VS FEB 15 1960

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| 1. PLACE OF DEATH a. COUNTY <u>Pemiscot</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pemiscot</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Caruthersville</u> | | c. CITY OR TOWN <u>Caruthersville, Mo</u> | |
| Length of stay in 1b <u>Life</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> | | d. STREET ADDRESS (If outside, give location) <u>Box 769 C'ville</u> | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Smith</u> Last <u>Smith</u> | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1960</u> | | |
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| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</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>9-8-1926</u> | 9. AGE (last birthday) <u>33</u> | IF UNDER 1 YEAR Months <u>4</u> Days <u>21</u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (City and state or country) <u>Lula Mississippi</u> | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
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| 13a. FATHER'S NAME <u>James Hall Jr.</u> | 13b. MOTHER'S MAIDEN NAME <u>Nellie Coleman</u> | 14. NAME OF HUSBAND OR WIFE <u>None</u> |
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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) <u>no</u> | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT Address <u>Edie Smith Caruthersville, Mo</u> |
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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) <u>Unknown, Natural- this person died while in sleep, with out medical attention.</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO (b) _____ | | |
| DUE TO (c) _____ | | |

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| 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 |
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| 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.) |
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| 20c. TIME OF INJURY Hour _____ s.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 _____ COUNTY _____ STATE _____ |
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>James G. Johnson</u> Coroner | 22b. ADDRESS <u>Wardell, Mo.</u> | 22c. DATE SIGNED <u>2-4-60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Jan-31-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u> | 23d. LOCATION (City, town, or county) (State) <u>Caruthersville, Missouri</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Noel C. Dean Caruthersville, Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>2-6-60</u> | 26. REGISTRAR'S SIGNATURE <u>Jack W Tipton</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 23 1960

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 Noel C Deane

Licensed Embalmer No. 394

P. O. Address Courthouse

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.