

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003588

FILED VS FEB 5 1960

2 769

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 3 mo. | c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS 3118 S. 7th St. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First Laura Middle Elizabeth Last Irions | | | 4. DATE OF DEATH Month 1 Day 20 Year 60 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1/11/1886 | 9. AGE (last birthday) 74 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Pemiscot Co., Mo. | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Wm. T. Irions Hayti, Missouri 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) Arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH 3mo. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) 420-0 | |
| | DUE TO (c) Generalized Arteriosclerosis | 3mo. |

| | | | |
|---|--|---|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal Bronchopneumonia - 2 days. | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____ | 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 **10-21-59** to **1-20-60** and last saw her/him alive on **1-20-60**
Death occurred at **9:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|-------------------------------------|---|
| 22a. SIGNATURE (Degree or title) John W. Beckham, M.D. | 22b. ADDRESS 5800 Arsenal | 22c. DATE SIGNED 1/21/60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 1-22-1960 | 23c. NAME OF CEMETERY OR CREMATORY Maple Cemetery |
| 23d. LOCATION (City, town, or county) Caruthersville, Missouri. | | (State) |

| | | |
|---|--|--|
| 24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. | 25. DATE RECD. BY LOCAL REG. JAN 22 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>mrc</i> |
|---|--|--|

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



Licensed Embalmer No. 4108

P. O. Address At Lewis

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.