

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

465-160-010060

FILED VS MAR 25 1960

43

Registration District No. Primary Registration District No. 3007 Registrar's No. 154

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Butler</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u> Length of stay in Ib <u>5 weeks</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Doctors Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ripley</u> c. CITY OR TOWN <u>Doniphan</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (if outside, give location) <u>Gen. Del.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Callie</u> Middle <u>DONNA</u> Last <u>Decker</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 1, 1878</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Ripley County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Louis J. Walker</u>			13b. MOTHER'S MAIDEN NAME <u>Melissa Payne</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) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hazel Fagan</u> Address <u>Malden, Missouri</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>Pulmonary edema</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Generalized Arterio Sclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 da</u> <u>30 da</u> <u>3</u>		
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 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 <u>1/24/60</u> to <u>2/26/60</u> and last saw her/him alive on <u>2/26/1960</u> Death occurred at <u>10:35 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. L. Kuehler M.D.</u>			22b. ADDRESS <u>Poplar Bluff Mo</u>		22c. DATE SIGNED <u>3/1/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Feb. 28, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Doniphan Cemetery Doniphan, Missouri</u>		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR ADDRESS <u>Edwards Funeral Home Doniphan, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>3/14/60</u>	26. REGISTRAR'S SIGNATURE <u>J. Kuehler</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 Gene St. Laurent

Licensed Embalmer No. 4809

P. O. Address Naylor

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.