

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-022433

XC-1206043 - REG. NO. A2580

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 356

STATE FILE NUMBER

FILED VS JUL 5 1960

1. PLACE OF DEATH a. COUNTY BUTLER				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY STODDARD					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 7 DAYS		c. CITY OR TOWN PUXICO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) NONE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First DEWEY Middle (NONE) Last ETHERIDGE				4. DATE OF DEATH Month JUNE Day 12 Year 1960					
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-9-96		9. AGE (last birthday) 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (City and state or country) HENDRICKSON, MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.	
13a. FATHER'S NAME MATTHEW ETHERIDGE			13b. MOTHER'S MAIDEN NAME BERNETTA PIGG			14. NAME OF HUSBAND OR WIFE NOT APPLICABLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT BROTHER Address RAY ETHERIDGE, 702 ASH ST., POPLAR BLUFF, MO		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNDIAGNOSED DISEASE, MANIFESTED BY UPPER GASTRO INTESTINAL HEMORRHAGE. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 7 DAYS	
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"/> N. <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 June 5, 1960 to June 12, 1960 Death occurred at 10:55 PM on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Robert S. Cohen ROBERT S. COHEN, M.D., Chief, Medical Svc. VA Hospital, Poplar Bluff, Mo.				22b. ADDRESS		22c. DATE SIGNED 6/16/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-16-60		23c. NAME OF CEMETERY OR CREMATORY City Cem.		23d. LOCATION (City, town, or county) Poplar Bluff, Mo.		(State)	
24. FUNERAL DIRECTOR Frank-Cotrell Poplar Bluff, Mo.				25. DATE RECD BY LOCAL REG. 6/21/60		26. REGISTRAR'S SIGNATURE <i>[Signature]</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 Edgar W. Luff

Licensed Embalmer No. 3394

P.O. Address Poplar Bl

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.