

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-023820

STATE FILE NUMBER

FILED VS JUL 8 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 259

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Marion</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>Pike</b>	
Length of stay in 1b <b>2 days</b>		c. CITY OR TOWN <b>Frankford</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Box #192 Frankford</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Elizabeth Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>Elmer</b>		Middle <b>Doolin</b>		Last <b>Doolin</b>		Month Day Year <b>June 29 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1889</b>	9. AGE (last birthday) <b>71</b>	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) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Frankford, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Turner Doolin</b>			13b. MOTHER'S MAIDEN NAME <b>Lucy Williams</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Cammie Doolin</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>192-24-1555</b>		17. INFORMANT Address <b>Mrs. Cammie Doolin Box 192 Frankford Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>						<b>acute</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						<b>8 mos.</b>	
DUE TO (b) <b>emphysema</b>							
DUE TO (c)							
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 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 <b>April, 1952</b> to <b>6/29/60</b> and last saw her him alive on <b>6/27/60</b>		Death occurred at <b>5:10 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>B. L. Murphy</i> (Degree or title) <b>B. L. Murphy, M.D.</b>			22b. ADDRESS <b>100 W. 6th, Hannibal, Mo.</b>			22c. DATE SIGNED <b>6/29/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 3, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frankford, Missouri</b>			
24. FUNERAL DIRECTOR <i>Geo. E. Roberts</i>		ADDRESS <b>1218 Broadway Hannibal, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6/30/60</b>		26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Leche by Lillian M. Norman</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 George E. Roberts  
George E. Roberts

Licensed Embalmer No. 2113

P. O. Address Hannibal, Missouri

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.