

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030131

FILED VS SEP 12 1960 08

Registration District No. \_\_\_\_\_ Primary Registration District No. 5423 Registrar's No. 14

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Dunklin</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> <b>Dunklin</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Senath Rt. 2</b>			Length of stay in lb <b>1 Year</b>		c. CITY OR TOWN <b>Senath Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Salem Township</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Rt. 2</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Yooulle</b> Middle <b>Foote</b> Last <b>Foote</b>				4. DATE OF DEATH Month <b>July</b> Day <b>8-</b> Year <b>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>2-2-1917</b>	9. AGE (last birthday) <b>43</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>Farm Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Monroe Louisiana</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Will Foote</b>			13b. MOTHER'S MAIDEN NAME <b>Sally Goodgain</b>			14. NAME OF HUSBAND OR WIFE <b>Ollie Foote</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>Unknown</b>		17. INFORMANT <b>Ollie Foote</b>		Address <b>Senath Mo. Rt. 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Loss of blood from Laceration of Left Brachial Artery.</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 checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Stabbed by wife.</b>			
20c. TIME OF INJURY Hour <b>7:00</b> a.m. _____ p.m. _____		Month, Day, Year <b>July 8, 60</b>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Salem Twp.</b>		COUNTY <b>Dunklin</b> STATE <b>Mo.</b>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <b>About 8.00P</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Quintoy</b> (Deceased or title) <b>Quintoy Terrence, M.D.</b>				22b. ADDRESS <b>Kennett Mo.</b>		22c. DATE SIGNED	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/14-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Booker Washington</b>		23d. LOCATION (City, town, or county) (State) <b>Centerville Township ILL.</b>	
24. FUNERAL DIRECTOR <b>Lentz Service</b>			ADDRESS <b>Kennett Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-1-60</b>		26. REGISTRAR'S SIGNATURE <b>Mabel T. Daughless</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS SEP 10 1960

OCT 7 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

*Edgar Lee Jones*

Licensed Embalmer No. 4433

P. O. Address Remest

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.