

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 30 1960

-60-031497

Registration District No. 254 Primary Registration District No. 4386 Registrar's No. 39

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Oregon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arkansas</u> b. COUNTY <u>Fulton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Thayer</u>		c. CITY OR TOWN <u>Mammoth Spring</u>	
Length of stay in 1b <u>1 week</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Judy</u> Middle <u>Caroline</u> Last <u>Dodge</u>	4. DATE OF DEATH Month <u>Aug.</u> Day <u>15.</u> Year <u>19 60</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-1876</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	11. BIRTHPLACE (City and state or country) <u>Alabama</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Simeon Waits</u>	13b. MOTHER'S MAIDEN NAME <u>Cardelia Thorne</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Asa Dodge, Mammoth Spring, Arkansas</u>
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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>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <u>Hypertensive CV disease</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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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
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21. I attended the deceased from 1955 to _____ and last saw her/him alive on _____
Death occurred at 3:00 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Mammoth Spring Ark</u>	22c. DATE SIGNED <u>8/19/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-18-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Field Creek</u>	23d. LOCATION (City, town, or county) (State) <u>Mammoth Spring, Arkansas</u>
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24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>8-24-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Leeland Carter*

Licensed Embalmer No. 4516

P. O. Address West Plains

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.