

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1960 **333**

3074

-60-033487

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **209**

NDED

1. PLACE OF DEATH a. COUNTY Scott b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston Length of stay in lb _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hospital Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Stoddard b. COUNTY State Mo. c. CITY OR TOWN Bell City, Missouri Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Rt. 1 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMATER Middle _____ Last FLEMING			4. DATE OF DEATH Month 8 Day 18 Year 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1886	9. AGE (last birthday) 74	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) house work		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and state or country) Coldwater, miss.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME James White			13b. MOTHER'S MAIDEN NAME Oliva Cox		14. NAME OF HUSBAND OR WIFE John Fleming	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address John Fleming Rt. 1 Bell City, 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) Cerebral hemorrhage DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH hrs. Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus, Atrial Fibrillation					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 checked="" 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 8-17-60 to 8-18-60 and last saw ^{her} _{him} alive on 8-17-60 Death occurred at 7:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) Thomas Chalmers MD				22b. ADDRESS Sikeston, Mo.		
22c. DATE SIGNED 8-20-60						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-18-60	23c. NAME OF CEMETERY OR CREMATORY Owms Cemetery		23d. LOCATION (City, town, or county) (State) Morrilton, Arkansas	
24. FUNERAL DIRECTOR ADDRESS Shetley Funeral Home Bell City, Mo.			25. DATE RECD. BY LOCAL REG. 8-27-60	26. REGISTRAR'S SIGNATURE Mrs. Ella Hunter		

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 Raymond L. Huff

Licensed Embalmer No. 4798

P. O. Address Berne,

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.