

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034333

FILED VS SEP 20 1960

Registration District No. 108 Primary Registration District No. 108-5423 Registrar's No. 5423 STATE FILE NUMBER 18

1. PLACE OF DEATH a. COUNTY <u>Dunkin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arkansas</u> b. COUNTY <u>Mississippi</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Arbyrd</u>		Length of stay in 1b <u>1 wk</u>		c. CITY OR TOWN <u>Leachville (Kurel)</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Ruth Goodrich Residence</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4 miles northwest of Leachville</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mada</u> Middle <u>Louvin</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6/3/92</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Forge Speakes</u>			13b. MOTHER'S MAIDEN NAME <u>Louvin Gibson</u>		14. NAME OF HUSBAND OR WIFE <u>Byron Myers</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT <u>Ruth Goodrich - Arbyrd, Mo</u> Address			
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>Coronary thrombosis & A</u> DUE TO (b) <u>Arterio Sclerotic Ht. Disease 1 1/2</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
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 <u> </u> a.m. <u> </u> 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 <u>18 June 60</u> to <u>29 June 60</u> and last saw her <u>live</u> on <u>23 June 60</u> Death occurred at <u>8 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>D. N. Rabman MD</u> (Degree or title)				22b. ADDRESS <u>Leachville, Ark</u>		22c. DATE SIGNED <u>29 June 60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/1/60</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Cade Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Dunkin County, Mo</u>			
24. FUNERAL DIRECTOR <u>Howard Funeral Service - Leachville, Ark</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>9-15-60</u>	26. REGISTRAR'S SIGNATURE <u>Mabel T. Daughers</u>		

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 H. H. Howard

Licensed Embalmer No. 3959

P. O. Address Blytheville, O.

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.