

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 27 1960

-60-035339

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 141 STATE FILE NUMBER

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>LACLEDÉ</u> | | 2. USUAL RESIDENCE Where deceased lived. If institution: Residence before admission) a. STATE <u>ARK.</u> b. COUNTY <u>MISS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEBANON</u> | | Length of stay in 1b <u>3 WKS</u> | c. CITY OR TOWN <u>BLYTHVILLE, ARK.</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 <u>WABACE HOSP.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED First <u>MARY</u> Middle <u>BARTO</u> Last <u>BARTO</u> | | | 4. DATE OF DEATH <u>SEPT 16 1960</u> Month <u>SEPT</u> Day <u>16</u> Year <u>1960</u> |
| 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>7-26-1896</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUSINESS WOMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (last birthday) <u>64</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. |
| 13a. FATHER'S NAME <u>WILLIAM BURGE</u> | | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | 11. BIRTHPLACE (City and state or country) <u>ENGLAND</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>486-40-9212</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | 17. INFORMANT <u>JOAN PERIAND</u> Address <u>BLYTHVILLE, ARK.</u> | |
| IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> | |
| DUE TO (b) <u>Acute Cardiac Dilatation</u> | | <u>17 hrs.</u> | |
| DUE TO (c) <u>Large Heart Arteriosclerotic Comp</u> | | <u>3 or 4 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fell 2 wks prior to hosp. Injured back leg</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 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.) <u>Fell backache aggrav. Condition</u> | |
| 20c. TIME OF INJURY Hour <u>12:00 p.m.</u> 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>7-12-48</u> to <u>Sept. 16, 1960</u> and last saw her <u>Sept 16, 1960</u> alive on <u>Sept 16, 1960</u> . Death occurred at <u>7:45 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Paula Jenkins MD</u> | | 22b. ADDRESS <u>Knight Bldg Lebanon Mo</u> | 22c. DATE SIGNED <u>9/19/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>9-16-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u> | 23d. LOCATION (City, town, or county) (State) <u>MTN GROVE MO</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>BARBER-EDWARDS MARSHFIELD</u> | | 25. DATE RECD. BY LOCAL REG. <u>9-19-1960</u> | 26. REGISTRAR'S SIGNATURE <u>Hella L. Day</u> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 16 1960

OCT 7 1960

OCT 14 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 me or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *R. W. Barber*

Licensed Embalmer No. 38
P. O. Address *Mr. Green*

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.

RECEIVED FOR THE BOARD OF HEALTH