

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035575

FILED VS OCT 1 0 1960

STATE FILE NUMBER

Registration District No. 240 Primary Registration District No. 5827 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <b>New Madrid</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lewis Twp.</b>		Length of stay in 1b <b>2 years</b>		c. CITY OR TOWN <b>Lilbourn</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>5 mi. N.W. of Lilbourn</b>				d. STREET ADDRESS (If outside, give location) <b>5 mi. N.W. of Lilbourn</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dessie</b> Middle <b>I.</b> Last <b>Hamilton</b>				4. DATE OF DEATH Month <b>September</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>4-11-95</b>	9. AGE (last birthday) <b>65</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months <b>5</b> Days <b>13</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ecro, Mississippi</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Vince Robins</b>			13b. MOTHER'S MAIDEN NAME <b>Nancy Dowdy</b>		14. NAME OF HUSBAND OR WIFE <b>L. S. Hamilton</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>None</b>		17. INFORMANT <b>L. S. Hamilton - Route 1 Lilbourn, Mo.</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>Cerebro - Vascular Accident</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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 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 <b></b> a.m. <b></b> p.m. <b></b>		Month, Day, Year <b></b>					
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 <b></b>	STATE <b></b>
21. I attended the deceased from <b>Dec 1959</b> to <b>23 Sept 60</b> and last saw her/him alive on <b>23 Sept 60</b> Death occurred at <b>3:50 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Charles Ponder</i>				22b. ADDRESS <b>New Madrid, Mo</b>		22c. DATE SIGNED <b>28 Sept 60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-26-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mounds Park</b>		23d. LOCATION (City, town, or county) <b>Near Lilbourn, Missouri</b>		
24. FUNERAL DIRECTOR <b>Ponder Funeral Home - Lilbourn, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>9-30-1960</b>		26. REGISTRAR'S SIGNATURE <i>H. L. Ponder Deputy</i>	

(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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Homer L. Ponder

Licensed Embalmer No. 336  
P. O. Address Lilbourn

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.