

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035645

FILED VS SEP 30 1960

Registration District No. 267 Primary Registration District No. 3049 Registrar's No. 155

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Pemiscot</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hayti</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hayti Hospital</u>				Length of stay in 1b Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> c. CITY OR TOWN <u>Catron</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2 miles west of Catron</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ola</u> Middle <u>Mae</u> Last <u>Office</u>				4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>1960</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</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>8-10-34</u>		9. AGE (last birthday) <u>26</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>9</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>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (City and state or country) <u>Charleston, Missouri</u>				12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13a. FATHER'S NAME <u>William Jennings</u>				13b. MOTHER'S MAIDEN NAME <u>Mamie Lee Gains</u>				14. NAME OF HUSBAND OR WIFE <u>Clarence Office</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>186-42-8609</u>		17. INFORMANT <u>Clarence Office, Catron, Missouri</u>									
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>Acute Food Poisoning</u> DUE TO (b) <u> </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 <u>11 Hrs</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 checked="" 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 <u> </u>		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 <u> </u> STATE <u> </u>							
21. I attended the deceased from <u>12:30 A.M. 9/19/60</u> to <u>4:00 A.M. 9/19/60</u> and last saw him alive on <u>Sept. 19, 1960</u> Death occurred at <u>4:00 A.M.</u> on <u> </u> the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>David R. Hensley MD</u>				22b. ADDRESS <u>211 N. 3rd. St. Lilbourn, Mo.</u>				22c. DATE SIGNED <u>9/19/60</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-22-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>				23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>							
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u>				ADDRESS <u> </u>				25. DATE RECD. BY LOCAL REG. <u>9-23-60</u>		26. REGISTRAR'S SIGNATURE <u>Charlotte E. Sloan</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 Harold D. Ponder

Licensed Embalmer No. 5030

P.O. Address Littleton, CO

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.