

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-039469

FILED VS NOV 15 1960

316

440

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pemiscot	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Length of stay in 1b 2 Mos.; 8 das.	c. CITY OR TOWN Portageville
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No.4,		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route 2

3. NAME OF DECEASED (Type or print) First ALFRED Middle _____ Last ROE			4. DATE OF DEATH Month October Day 26, Year 1960	
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1902	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months 4 Days 21	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Common labor and farm work.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kentucky	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Thomas Roe	13b. MOTHER'S MAIDEN NAME Tavie Henry	14. NAME OF HUSBAND OR WIFE Lizzie _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Records, State Hospital No.4, Farmington, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia - - - - -		INTERVAL BETWEEN ONSET AND DEATH 29 das.
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 (g) Mental deficiency, mild, with left hemiplegia ; fractured left arm.		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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Probable fall on ward of mental hospital
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 9-27-60	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Ward of mental hospital	20f. CITY, TOWN, OR LOCATION St. Francois Twp. St. Francois Mo.
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACED OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Ward of mental hospital	20f. CITY, TOWN, OR LOCATION St. Francois Twp. St. Francois Mo.
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21. I attended the deceased from August 18, 1960 to Oct. 26, 1960 and last saw him alive on Oct. 26, 1960
Death occurred at 12:15 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John A. Brennan M.D.</i> (Degree or title)	22b. ADDRESS State Hospital No. 4 Farmington, Missouri	22c. DATE SIGNED 10-26-60.
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 28, 1960	23c. NAME OF CEMETERY OR CREMATORY Portageville Cemetery	23d. LOCATION (City, town, or county) (State) Portageville, Missouri
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24. FUNERAL DIRECTOR Delisle Funeral Home, Portageville, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. Oct. 26, 1960	26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 *C. H. Cozart*

Licensed Embalmer No. 40

P. O. Address Farmington

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.