

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 28 1960

-60-041204

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 627

1. PLACE OF DEATH a. COUNTY BUTLER				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 POPLAR BLUFF		Length of stay in 1b 175 DAYS		c. CITY OR TOWN CARUTHERSVILLE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1406 SCHULTZ AVENUE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIE Middle NONE Last STINSON				4. DATE OF DEATH Month NOVEMBER Day 12 Year 1960				
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 9-12-84	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (City and state or country) CLINTON, KENTUCKY		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JOHN STINSON			13b. MOTHER'S MAIDEN NAME MINNIE GIBBS			14. NAME OF HUSBAND OR WIFE MINNIE L. STINSON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address MINNIE STINSON, WIFE, SAME AS 2c&d				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, SIGMOID COLON, INOPERABLE.							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Years.	
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) 1. CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA. 2. BRONCHIECTASIS.						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 _____ a.m. _____ 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 MAY 21, 1960 to NOV. 12, 1960 and last saw her/him on _____				Death occurred at 4:40 PM on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) R. B. TURNER, M.D., Actg. Chief, Medical Svc. VA Hospital, Poplar Bluff, Mo.				22b. ADDRESS		22c. DATE SIGNED 11/15/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-12-60	23c. NAME OF CEMETERY OR CREMATORY Caruthersville Cem.		23d. LOCATION (City, town, or county) (State) Caruthersville, Mo.			
24. FUNERAL DIRECTOR Frank-Cotrell Poplar Bluff, Mo.				25. DATE RECD. BY LOCAL REG. 11/19/60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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 Edgar W. L. Jones
Licensed Embalmer No. _____

: P. O. Address _____

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.