

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046900

ED VS DEC 23 1960

Registration District No. 237 Primary Registration District No. 4353 Registrar's No. 10

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gideon</u>		Length of stay in 1b <u>1 1/2</u> years		c. CITY OR TOWN <u>Gideon</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</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 (Type or print) First <u>WILLIAM</u> Middle <u>ARTHUR</u> Last <u>HOUSE</u>				4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1960</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</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>July 21, 1884</u>		9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>W.A. House</u>				13b. MOTHER'S MAIDEN NAME <u>unknown</u>				14. NAME OF HUSBAND OR WIFE <u>Nettie House</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>none</u>		17. INFORMANT Address <u>Nettie House Gideon, 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>Broncho-pneumonia</u> DUE TO (b) <u>Senility</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</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 type="checkbox"/> N. <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u>12-13-60</u> to <u>12-16-60</u> and last saw <u>him</u> alive on <u>12-15-60</u> Death occurred at <u>1:10 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>E. G. Hopkins M.D.</u> (Degree or title)						22b. ADDRESS <u>Gideon, Mo</u>			22c. DATE SIGNED <u>12-17-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>Dec. 18, 1960</u>		23c. NAME OF CEMETERY OR GREMATORY <u>Mt. Gilead Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Clarkton Missouri</u>					
24. FUNERAL DIRECTOR <u>Landess Funeral Home, Campbell, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>12-18-60</u>		26. REGISTRAR'S SIGNATURE <u>Wm F Hopkins</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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Christine M. Land

Licensed Embalmer No. 422

P. O. Address Campbell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.