

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-046909**

OFFICE OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

UNDECEASED

FILED VS JAN 5 1961

Registration District No. 240 Primary Registration District No. 824 Registrar's No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>New Madrid</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Conran-La Tronche</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>New Madrid</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>OR TOWN</b>		Length of stay in 1b <b>life</b>		c. CITY OR TOWN <b>Conran</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Resident</b>		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)				4. DATE OF DEATH			
First <b>VELMER</b>		Middle <b>HUTSON</b>		Last <b>FURLONG</b>		Month Day Year <b>Dec. 24, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4/25/1913</b>	9. AGE (last birthday) <b>47</b>	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) <b>Day-Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Conran, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Furlong</b>			13b. MOTHER'S MAIDEN NAME <b>Susie Powers</b>		14. NAME OF HUSBAND OR WIFE <b>Colleen Furlong</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>489-18-5218</b>		17. INFORMANT Address <b>W. A. Newton Conran, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b>						<b>1 week</b>	
DUE TO (b) <b>Pulmonary Tuberculosis</b>						<b>3 years</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 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 <b>12-23-60</b> to <b>12-24-60</b> and last saw her/him alive on <b>12-24-60</b>				Death occurred at <b>4:40</b> <b>A</b> .m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>James O. Cameron M.D.</b>			22b. ADDRESS <b>Lilbourn Mo</b>			22c. DATE SIGNED <b>12-28-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/26/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mounds Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Near New Madrid, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>RICHARDS New Madrid, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>12-30-1960</b>		26. REGISTRAR'S SIGNATURE <b>H. L. Gordon Deputy</b>		

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 *Samuel Helgerson*

Licensed Embalmer No. 5100

P. O. Address New Mo.

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