

UNITED STATES DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH FILED VS JAN 13 1967

-60-046979

STATE FILE NUMBER

Registration District No. 267 Primary Registration District No. 3049 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>Pemiscot</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pemiscot</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hayti</u>		Length of stay in 1b <u>4hrs</u>		c. CITY OR TOWN <u>Caruthersville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hayti Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Chaffin Add. E. 10th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Hubert</u> Last <u>Alston</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>April 29, 1905</u>	9. AGE (last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u> Hours <u></u> Min. <u></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>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gro. Store</u>		11. BIRTHPLACE (City and state or country) <u>DeCatur Co. Tennessee</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Wm. Fredrick Alston</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Wallace</u>		14. NAME OF HUSBAND OR WIFE <u>Leon Alston</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>495-14-2052</u>		17. INFORMANT Address <u>Leona Alston Caruthersville, Mo</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>Hypertensive C.V. disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral accident</u> DUE TO (c) <u>Hypertensive C.V. disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>9 mos</u>	
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.) <u></u>			
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <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.) <u></u>		20f. CITY, TOWN, OR LOCATION COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>12-23-60</u> to <u>12-23-60</u> and last saw him alive on <u>12-23-60</u> Death occurred at <u>3:35 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>O. W. Cook M.D.</u> (Do not use title)				22b. ADDRESS <u>Caruthersville, Mo</u>		22c. DATE SIGNED <u>Dec 27-28-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 26, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Little Prairie</u>		23d. LOCATION (City, town, or county) (State) <u>Caruthersville, Mo.</u>	
24. FUNERAL DIRECTOR <u>Noel C. Dean C'Ville Mo</u>				25. DATE RECD. BY LOCAL REG. <u>1-4-61</u>		26. REGISTRAR'S SIGNATURE <u>Charlotte E. Sloan</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 19 1961

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

Walter D. Dean

Licensed Embalmer No. *3941*

P. O. Address *Cambridge*

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.