

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046996

FILED VS JAN 4 1967

STATE FILE NUMBER

Registration District No. 267 Primary Registration District No. 5089 Registrar's No. 214

ENDED

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>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hayti</u>		Length of stay in 1b <u>1 wk.</u>	c. CITY OR TOWN <u>Catron</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hayti Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 mi. W. of Catron</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Pearline</u> Middle <u>Washington</u> Last _____			4. DATE OF DEATH Month <u>Oct.</u> Day <u>20</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-2-23</u>	9. AGE (last birthday) <u>36</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u> Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Golden Lake, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Washington</u>		13b. MOTHER'S MAIDEN NAME <u>Tellolder Washington</u>		14. NAME OF HUSBAND OR WIFE _____	
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>489-40-1710</u>		17. INFORMANT <u>Frank Robertson-Catron, Mo.</u> Address _____	

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>Lower Nephron Nephrosi</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Surgical Shock & Peritonitis</u>		<u>9 days</u>
	DUE TO (c) <u>Ruptured Duodenum</u>		<u>9 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 checked="" 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 <u>10/13/60</u> to <u>10/20/60</u> and last saw her/him alive on _____ Death occurred at <u>1:45 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>For Son L. Bushnell Jr. MD</u>		22b. ADDRESS <u>Hayti, Mo.</u>		22c. DATE SIGNED <u>12/24/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-23-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Simmons Burial Park</u>		23d. LOCATION (City, town, or county) <u>Catron, Mo.</u>	
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u>		ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>12-24-60</u>	26. REGISTRAR'S SIGNATURE <u>Charlotte E. Sloan</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 JAN 4 ST

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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address Lilbourn,

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