

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048966
STATE FILE NUMBER

Registration District No. 48 Primary Registration District No. 3007 Registrar's No. 169

FILED APR 17 1961

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOWELL	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in lb 3 DAYS	c. CITY OR TOWN MOUNTAIN VIEW Inside Limits Yes <input type="checkbox"/> No <input checked="" 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) ROUTE ONE, BOX 337 Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HUGH Middle GRIFF Last DeBORD	4. DATE OF DEATH Month NOVEMBER Day 17 , Year 1960
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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 11-7-91	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRUSH MAKER	10b. KIND OF BUSINESS OR INDUSTRY BRUSH MAKING	11. BIRTHPLACE (City and state or country) WILLOW SPRINGS, MO.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME DRURY DeBORD	13b. MOTHER'S MAIDEN NAME MARTHA COX	14. NAME OF HUSBAND OR WIFE LILLIAN DeBORD
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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 LILLIAN DeBORD, WIFE, RT. 1, MT. VIEW, MO.	Address -
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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) PULMONARY CONGESTION, ACUTE, BILATERAL.		2 to 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE, CHRONIC.	UNKNOWN
	DUE TO (c) UREMIA, ACUTE.	ONE WEEK

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1. NEPHRITIC CYSTS, MULTIPLE, CHRONIC. 2. CORONARY ARTERY DISEASE, CHRONIC. 3. PERICARDITIS, ACUTE, LOCALIZED.	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA	20f. CITY, TOWN, OR LOCATION VA	COUNTY _____ STATE _____
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21. attended the deceased from **NOVEMBER 14, 1960** to **NOV. 17, 1960** and last saw him alive on _____
Death occurred at **5:05PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. LESTER HARWELL, M.D., Actg. Pathologist	22b. ADDRESS VA Hospital, Poplar Bluff, Mo.	22c. DATE SIGNED 11/18/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-18-60	23c. NAME OF CEMETERY OR CREMATORY Mt. View Cem.	23d. LOCATION (City, town, or county) (State) Mt. View, Mo.
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24. FUNERAL DIRECTOR Frank-Cotrell Poplar Bluff, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 4/8/61	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

MS APR 18 1961

APR 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 Charles E. Mungler

Licensed Embalmer No. 4877

P. O. Address Poplar Bluff

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.