

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005976

STATE FILE NUMBER

Registration District No. 239 Primary Registration District No. 4356 Registrar's No. 5

AMENDED

FILED VS FEB 17 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Parma</u>		Length of stay in 1b <u>39 yrs.</u>	c. CITY OR TOWN <u>Parma</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Parma</u>
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>May</u> Last <u>Harchous</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>cauc.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20 1887</u>
9. AGE (last birthday) <u>73 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Jasper County Ill.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>James P. Robinson</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth McHaney</u>		14. NAME OF HUSBAND OR WIFE <u>deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address <u>Harold Harchous Parma 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>Cardiac Insufficiency</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>old age</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 <u>8</u> a.m. <u>AM</u> Month, Day, Year <u>2-4-61</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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>11-20-1961</u> to <u>Feb. 4, 1961</u> and last saw her <u>alive</u> on <u>2-4-61</u> Death occurred at <u>8 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Dr. Geo. W. Husted, M.D.</u> (Degree or title)		22b. ADDRESS <u>Parma, Mo.</u>	
22c. DATE SIGNED <u>2/6/61</u> (State)		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	
23b. DATE <u>Feb. 6 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	
23d. LOCATION (City, town, or county) <u>Malden Missouri</u>		24. FUNERAL DIRECTOR <u>Watkins and Sons Parma Mo.</u> ADDRESS	
25. DATE RECD. BY LOCAL REG. <u>Feb. 6, 1961</u>		25. REGISTRAR'S SIGNATURE <u>Dr. Geo. W. Husted M.D.</u>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Carl M. Watkins*

Licensed Embalmer No. 4764

P. O. Address Depto. M. O.

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.