

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

**=61-009890**

Registration District No. 239 Primary Registration District No. 4356 Registrar's No. 6

STATE FILE NUMBER

AMENDED **F** LED MAR 20 1961

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>New Madrid</u>                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. 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>79 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 type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/> |

|  |                               |   |  |  |   |
|--|-------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Martha</u> Middle <u>Ellen</u> Last <u>Hicks</u>                     |                               |   | 4. DATE OF DEATH<br>Month <u>Feb.</u> Day <u>24</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"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 26, 1880</u>                                | 9. AGE (last birthday) <u>80 yrs.</u>                  | IF UNDER 1 YEAR<br>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>retired housewife</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country) <u>Columbus Ind.</u>      | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>                 |   |
| 13a. FATHER'S NAME <u>Jacob Miller</u>   |                               | 13b. MOTHER'S MAIDEN NAME <u>Mary Guinn</u>   |  | 14. NAME OF HUSBAND OR WIFE <u>deceased</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.   |  | 17. INFORMANT Address <u>Mrs. Ira Grubbs Parma Mo.</u> |   |

|  |  |  |   |
|--|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>History from family, cardiac, Decomp.</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |  |  |   |
| DUE TO (b) <u>Age</u><br>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.<br><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<br>Hour <u>10:10</u> a.m. <u>P.M.</u><br>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 10:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                |   |   |                                |
|--|--------------------------------|---|---|--------------------------------|
| 22. SIGNATURE (Degree or title) <u>Dr. Geo. W. Huat, M.D. Local Regis.</u> |                                | 22b. ADDRESS <u>Parma, Mo.</u>                          |   | 22c. DATE SIGNED <u>3/3/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>                    | 23b. DATE <u>Feb. 27, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u> | 23d. LOCATION (City, town, or county) <u>Parma Mo.</u>  |                                |
| 24. FUNERAL DIRECTOR ADDRESS <u>Watkins And Sons Parma Mo.</u>             |                                | 25. DATE RECD. BY LOCAL REG. <u>3/3/61</u>              | 26. REGISTRAR'S SIGNATURE <u>Dr. Geo. W. Huat, M.D.</u> |                                |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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. Walker

Licensed Embalmer No. 4964

P. O. Address Septemo

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.