

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-012808

STATE FILE NUMBER

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 58 II

FILED APR 24 1961

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BUTLER</b>  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b> Length of stay in 1b <b>15 DAYS</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>STODDARD</b>  c. CITY OR TOWN <b>GRAY RIDGE</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>NONE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>NONE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>JOHN</b> Middle <b>THOMAS</b> Last <b>JULIAN</b>			<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>4</b> Year <b>1961</b>		
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8-19-92</b>	<b>9. AGE (last birthday)</b> <b>68</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>BARBER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>BARBER</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>NEWPORT, ARKANSAS</b>	
<b>13a. FATHER'S NAME</b> <b>THOMAS D. JULIAN</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>OLA RAZER</b>		
<b>14. NAME OF HUSBAND OR WIFE</b> <b>CAMILLIA JULIAN</b>					

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>	<b>16. SOCIAL SECURITY NO.</b> <b>UNKNOWN</b>	<b>17. INFORMANT</b> Address <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION AND PULMONARY INFARCTION, ACUTE</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> _____	<b>COUNTY</b> _____	<b>STATE</b> _____
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21. I attended the deceased from **MARCH 20, 1961** to **APRIL 4, 1961** and ~~was present at~~ <sup>her</sup> ~~his~~ death on **APRIL 4, 1961** at **8:00 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22. SIGNATURE</b> (Degree or title)  <b>ERNEST M. TAPP, M.D., DIRECTOR</b> , Prof. Svcs. VA Hospital, Poplar Bluff, Mo.	<b>22b. ADDRESS</b> _____	<b>22c. DATE SIGNED</b> <b>4/7/61</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>	<b>23b. DATE</b> <b>4-7-61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Garden of Memories Cem. Sikeston, Mo.</b>	<b>23d. LOCATION</b> (City, town, or county) (State) _____
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Watkins &amp; Sons</b> Dexter, Mo.	<b>25. DATE RECD. BY LOCAL REG.</b> <b>4/13/61</b>	<b>26. REGISTRAR'S SIGNATURE</b> 
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(Licensed Embalmer's Statement on Reverse Side)

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



Licensed Embalmer No. 4964

P. O. Address Lytlewood

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.