

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUN 2 1961

-61-020107

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 6152 Registrar's No. 38

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Stoddard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stoddard					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Dexter		Length of stay in 1b OR TOWN Few Wks.		c. CITY OR TOWN Bernie, Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Green Meadows Rest Hm			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Minnie Reed Bethune				4. DATE OF DEATH Month May Day 17 Year 1961					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2-16-1878	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Mississippi		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME William Carnes			13b. MOTHER'S MAIDEN NAME Mary -----			14. NAME OF HUSBAND OR WIFE Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Mae Harrellson Bernie, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure								INTERVAL BETWEEN ONSET AND DEATH 4 Day	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Cerebral hemorrhage							
		DUE TO (c) High Multiple Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (b)						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 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 April 1960 to May 17th 61 and last saw her alive on May 17th 61 Death occurred at 5:00 p.m. 5/17/61 on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Sam S. Davis, M.D. (Degree or title)				22b. ADDRESS Bernie, Mo.				22c. DATE SIGNED 5-17-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial & Removal		23b. DATE 5-20-61	23c. NAME OF CEMETERY OR CREMATORY Synder Cemetery		23d. LOCATION (City, town, or county) Near Hamburg, Arkansas		23e. STATE Arkansas		
24. ADDRESS Duffie-Rainey Bernie, Mo.				25. DATE RECD. BY LOCAL REG. 5/24/61		26. REGISTRAR'S SIGNATURE Delmar V. Jenkins			

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 Raymond L. Duffie

Licensed Embalmer No. 4798

P. O. Address Berne, N.J.

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.