

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-036058

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 443 Primary Registration District No. 3007 Registrar's No. 370

FILED OCT 31 1961

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY IZARD	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 1 DAY	c. CITY OR TOWN OXFORD 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) NONE Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HERCHEL Middle RAY Last HELM	4. DATE OF DEATH Month OCTOBER Day 6 Year 1961
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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 5-31-08	9. AGE (last birthday) 53	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) OXFORD, ARKANSAS	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME WALTER HELM	13b. MOTHER'S MAIDEN NAME SUSIE LAWSON	14. NAME OF HUSBAND OR WIFE BESSIE HELM
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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 WWII	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT VA HOSPITAL RECORDS, POPLAR BLUFF, 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 24 HOURS
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION.		
DUE TO (b) CORONARY THROMBOSIS.		
DUE TO (c) ARTERIOSCLEROSIS.		

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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 VA	COUNTY	STATE
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21. I attended the deceased from October 6, 1961 to October 6, 1961 and last saw him alive on Death occurred at 4:40AM m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Deceased or title) Robert S. Cohen ROBERT S. COHEN, M.D., Chief, Medical Svc.	22b. ADDRESS VA Hospital, Poplar Bluff, Mo.	22c. DATE SIGNED 10/11/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/9/61	23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	23d. LOCATION (City, town, or county) (State) Oxford, Arkansas
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24. FUNERAL DIRECTOR Carter Funeral Service	ADDRESS Salem, Arkansas	25. DATE RECD. BY LOCAL REG. 10-25-1961	26. REGISTRAR'S SIGNATURE <i>Thelma Graham</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 Philip J. Casserly
Licensed Embalmer No. 4618

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.