

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036231

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 66 Primary Registration District No. _____ Registrar's No. 27

FILED NOV 6 1961

1. PLACE OF DEATH a. COUNTY <u>CHARITON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>CHARITON</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>YELLOW CREEK TWP.</u>		Length of stay in 1b	c. CITY OR TOWN <u>BYNUMVILLE</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 1/2 mi W. Rothville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>RURAL</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT LEE POPE</u>			4. DATE OF DEATH Month Day Year <u>NOV. 1 1961</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-1911</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>6 19</u>	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>FLOYD CO. TEX.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>W.H. POPE</u>	13b. MOTHER'S MAIDEN NAME <u>PHOENIX DOWNEY</u>	14. NAME OF HUSBAND OR WIFE <u>MARGIE POPE</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>MRS. ROBT. L. POPE</u> Address <u>BYNUMVILLE MO.</u>
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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: IMMEDIATE CAUSE (a) <u>Guns shot wound - w. head.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
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 checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART III or PART II of item 18.) <u>accidental - shot in head</u>
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20c. TIME OF INJURY Hour <u>2:00</u> p.m. Month, Day, Year <u>11-1-61</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>3 1/2 mile W. of Rothville. mo</u>	20f. CITY, TOWN, OR LOCATION <u>Chariton MO.</u>
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 3:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M.D. Guinn</u> (Degree or title)	22b. ADDRESS <u>Coroner of Chariton County - Blytheville mo</u>	22c. DATE SIGNED <u>11-4-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-4-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCKNEY CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>LOCKNEY TEXAS</u>
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24. FUNERAL DIRECTOR <u>MILLER-TILLOTSON</u>	ADDRESS <u>MARCELING MO.</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 2 1961</u>	26. REGISTRAR'S SIGNATURE <u>Howie Smith</u>
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
ITEM NO.
BY AFFIDAVIT OF

NOV 14 1961

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 Silber K. Tidate

Licensed Embalmer No. 4508

P. O. Address Marceline

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.