

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036459

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 163

FILED OCT 16 1961

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett</u>		Length of stay in 1b	c. CITY OR TOWN <u>Arbyrd</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>Dunklin Co. Memorial Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. 1</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Nanie</u> Middle <u>Isabelle</u> Last <u>Mason</u>	4. DATE OF DEATH Month <u>Oct.</u> Day <u>4,</u> Year <u>1961</u>
--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/21/1892</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
----------------------	-------------------------------	---	-----------------------------------	----------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Bover, Ark.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	-----------------------------------	--	--

13a. FATHER'S NAME <u>Jack Cudd</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Brown</u>	14. NAME OF HUSBAND OR WIFE <u>Divorced</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>Chester Mason Rt. 1, Arbyrd, Mo.</u>
---	-------------------------	--

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>Pulmonary Edema</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

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 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 <u></u> Month, Day, Year <u></u>	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 <u>Oct 4, 1961</u> to <u>Oct 4, 1961</u> and last saw her alive on <u>10-4-61</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>Leo J. Benson MD</u>	22b. ADDRESS <u>Senath Mo</u>	22c. DATE SIGNED <u>10/16/61</u> (Date)
---	----------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/6/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lulu</u>	23d. LOCATION (City, town, or county) (Near) <u>Senath, Mo.</u>
--	-------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <u>McDaniel Funeral Service, Senath, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 10-1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Hushard</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 D. J. Isbell

Licensed Embalmer No. 4970

P. O. Address Senath, MO.

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.