

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037558

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 94

STATE FILE NUMBER

AMENDED

FILED OCT 25 1961

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Barry	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon		Length of stay in lb 18 days	c. CITY OR TOWN Purdy Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State San.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rt. #2 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First James Middle David Last Dent			4. DATE OF DEATH Month 10 Day 9 Year 61		
5. SEX Male	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 3-22-84	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James Dent		13b. MOTHER'S MAIDEN NAME Evangeline Van Sant		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			17. INFORMANT Hosp. Record Address		

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 sev. hrs.
IMMEDIATE CAUSE (a) Hypoxia		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Pulmonary T.B.C. Miliary	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis generalized		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.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 9-22-61 to 10-9-61 and last saw ^{her}him alive on 10-9-61
Death occurred at 11:55 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Geo. H. Hobbs, M.D.</i> (Degree or title)	22b. ADDRESS Mo. State San.	22c. DATE SIGNED 10-10-61
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10-10-61	23c. NAME OF CEMETERY OR CREMATORY Dent Cemetery	23d. LOCATION (City, town, or county) near Jachet	23e. STATE Ark.
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24. FUNERAL DIRECTOR Miller-Sisco	ADDRESS PeaRidge, Ark.	25. DATE RECD. BY LOCAL REG. 10-11-61	26. REGISTRAR'S SIGNATURE <i>Bina Shelton Deputy</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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. _____

P. O. Address _____

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.