

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040880

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. \_\_\_\_\_

AMENDED

**FILED DEC 11 1961**

1. PLACE OF DEATH a. COUNTY <u>Howell</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arkansas</u> b. COUNTY <u>Fulton</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in lb <u>1 day</u>	c. CITY OR TOWN <u>Mammoth Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>West Plains Memorial Hosp.</u>		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 checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEMUEL</u> Middle <u>BUTLER</u> Last <u>HENSLEY</u>			4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-82</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Botanist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(Ret.) Botanist</u>	11. BIRTHPLACE (City and state or country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>(Unknown)</u>		13b. MOTHER'S MAIDEN NAME <u>(Unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>(Unknown)</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>Hospital Records and Insurance Papers.</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>Cerebral Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20/7/61</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)				
		DUE TO (c)				
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 _____ 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 <u>20-7-61</u> to <u>21-7-61</u> and last saw him alive on <u>21-7-61</u> Death occurred at <u>7:30 A</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>[Signature]</u> (Degree or title)			22b. ADDRESS <u>West Plains, Missouri</u>		22c. DATE SIGNED <u>8 Dec 61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/27/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mammoth Springs, Arkansas</u>			
24. FUNERAL DIRECTOR <u>Bryson Funeral Home</u>		ADDRESS <u>Mammoth Springs Arkansas</u>	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>Harold W. M. D.</u>		

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF Holland Smith, Medical Certification

**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 Alvin Byrson

Licensed Embalmer No. 980

P. O. Address Marion, N. C.

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.