

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043749

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 482 STATE FILE NUMBER

FILED JAN 10 1962

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u>		Length of stay in lb <u>1 wk</u>	c. CITY OR TOWN <u>Malden</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>Poplar Bluff hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Earl Cecil Dell</u>			4. DATE OF DEATH Month Day Year <u>12-23-1961</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>3-26-1921</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Catting, Arki.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>Ed Dell</u>	13b. MOTHER'S MAIDEN NAME <u>Rusie Uedera</u>	14. NAME OF HUSBAND OR WIFE <u>Agnes Dell</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.	17. INFORMANT Address <u>Charley Dell, St Louis</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>Tetanus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Laceration of hand 1 wk before coming to the hospital.</u>	
	DUE TO (c) <u>Coming to the hospital.</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
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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 I or PART II of item 18.) <u>Powder saw laceration of finger 1 wk before onset of Tetanus.</u>
20c. TIME OF INJURY Hour a.m. p.m. <u>?</u>	Month, Day, Year <u>12/16/61</u>	

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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
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21. I attended the deceased from 9:30 12/16/61 to 12/23/61 and last saw him alive on 12/23/61
Death occurred at 9:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William P. Durnwald</u>	22b. ADDRESS <u>215 east St Poplar Bluff, Mo</u>	22c. DATE SIGNED <u>1/2/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-26-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Malden Park</u>	23d. LOCATION (City, town, or county) (State) <u>Malden, Mo.</u>
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24. FUNERAL DIRECTOR <u>Lloyd Russell Liggett</u>	ADDRESS <u>Ark, 1-5-1962</u>	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>Helma Graham</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

JAN 18 1962

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 Lloyd Russell

Licensed Embalmer No. 509-9

P. O. Address Piquette

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.