

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043833

Registration District No. 53 Primary Registration District No. 0000 Registrar's No. 488 STATE FILE NUMBER

AMENDED

**FILED DEC 26 1961**

a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Burfordsville</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
Length of stay in lb <u>40 yrs</u>		c. CITY OR TOWN <u>Burfordsville</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>MAIN Street</u>		d. STREET ADDRESS (If outside, give location) <u>MAIN Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Columbus Palmer Dockins</u>			4. DATE OF DEATH Month Day Year <u>Dec. 2 1961</u>				
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</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>9/11/1900</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>		11. BIRTHPLACE (City and state or country) <u>Cape Girardeau</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Frank Dockins</u>		13b. MOTHER'S MAIDEN NAME <u>Marzilla Bridges</u>		14. NAME OF HUSBAND OR WIFE <u>Phyllis Dockins</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>			17. INFORMANT <u>Bruce Dockins Jackson, 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) Cerebral Vascular Occlusion INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebrovascular disease

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.  Yes  No  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 4/4/59 to 12/2/61 and last saw him alive on 11/27/61  
 Death occurred at 5 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 M. Eaton M.D.</u>	22b. ADDRESS <u>714 Broadway, Cape Girardeau</u>	22c. DATE SIGNED <u>12/16/61</u>
---	--	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/4/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights Jackson, Mo.</u>	23d. LOCATION (City, town or county) (State) <u>Jackson, Mo.</u>
---	----------------------------	--	--

24. FUNERAL DIRECTOR <u>McCombs Jackson, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-20-1961</u>	26. REGISTRAR'S SIGNATURE <u>Gene Kasten</u>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

DEC 27 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 C. J. Lovberg  
Licensed Embalmer No. 3810

P. O. Address Cape Girardeau

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.