

# SOUTH DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

*Calderwell*

-61-045743

STATE FILE NUMBER

AMENDED

FILED JAN 12 1967
Primary Registration District No. 3049
Registrar's No. 202

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Pemiscott</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Pemiscott</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hayti</b>		Length of stay in 1b		c. CITY OR TOWN <b>Holland</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pemiscott Community</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>James Alfred Jones</b>				<b>4. DATE OF DEATH</b> Month <b>12</b> Day <b>18</b> Year <b>1961</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-6-1886</b>	9. AGE (last birthday) <b>75</b>	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) <b>Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>New Madrid Mo.</b>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>J.W. Jones</b>			13b. MOTHER'S MAIDEN NAME <b>Dont Know</b>			14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Joan Little Blytheville Ark.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Longtime Tuberculosis</b> DUE TO (b) <b>H &amp; U D</b> DUE TO (c) <b>Prostate Tumor</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>3-186</b> <b>10-24</b> <b>15-20</b>	
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.		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 <b>6-5-61</b> to <b>7-12-61</b> and last saw him alive on <b>12-17-61</b> Death occurred at <b>6 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>James Calderwell</i> (Name or title)				22b. ADDRESS <b>H&amp;F Mo</b>		22c. DATE SIGNED <b>12-30-61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-19-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood</b>		23d. LOCATION (City, town, or county) (State) <b>Blytheville Ark.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Cobb Funeral Home Blytheville Ark.</b>			25. DATE RECD. BY LOCAL REG. <b>1-3-62</b>		26. REGISTRAR'S SIGNATURE <i>Charlotte E. Sloan</i>			

DOCUMENT

MEDICAL CERTIFICATION

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 James B. Stone

Licensed Embalmer No. 3100

P. O. Address Blytheville

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.