

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-045994

MENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3054 Registrar's No. 489

AMENDED

FILED DEC 19 1961

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u> Length of stay in 1b <u>3 Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u> c. CITY OR TOWN <u>Flat River</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>7 Bennett St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED First Middle Last <u>LUTHER MAYBERRY</u>			4. DATE OF DEATH Month Day Year <u>Dec. 15, 1961</u>			
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>3/6/1881</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Mill Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lead Mining</u>	11. BIRTHPLACE (City and state or country) <u>Goodwater, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Marion Mayberry</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Ann Merritt</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Luther Mayberry</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servic <u>No</u>			17. INFORMANT Address <u>Mrs. Lila Pippin Pine Lawn, 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) <u>Arteriosclerosis Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility</u> DUE TO (c) <u> </u>					PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hepatitis due to unknown cause</u>	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>Nov. 1961</u> to <u>Dec 15, 1961</u> and last saw him alive on <u>Dec 15, 1961</u> Death occurred at <u>2:45 P. m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>R. A. Hickstop M.D.</u>			22b. ADDRESS <u>Farmington, Mo.</u>		22c. DATE SIGNED <u>12/16/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/17/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>	23d. LOCATION (City, town, or county) <u>Farmington, Mo.</u>	(State)		
24. FUNERAL DIRECTOR ADDRESS <u>Murphy L. Sparks Flat River, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 16, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>			

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 Murphy Sparks
Licensed Embalmer No. 4256
P. O. Address 1st Ave. St.

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.