

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-047500

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 251

FILED JAN 2 1962

1. PLACE OF DEATH a. COUNTY <u>Scott</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u> Length of stay in lb c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hosp</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Scott</u> c. CITY OR TOWN <u>Sikeston</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>814 VERNON ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>B.</u> Last <u>Caudle</u>			4. DATE OF DEATH Month <u>December</u> Day <u>23</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>4-12-1887</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (City and state or country) <u>Greenfield Tenn.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Jim Caudle</u>			13b. MOTHER'S MAIDEN NAME <u>Nannie Kimery</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Preston Alley Sikeston 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>arteriosclerotic heart disease</u> DUE TO (b) <u>gen. arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH ? ?	
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 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>12/16/61</u> to <u>12/23/61</u> and last saw him alive on <u>12/23/61</u> Death occurred at <u>10:25 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Wm. C. Cutchlow M.D.</u>				22b. ADDRESS <u>Sikeston mo</u>		22c. DATE SIGNED <u>12/23/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 25, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>		23d. LOCATION (City, town, or county) (State) <u>Blytheville ARK.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Robt Funeral Home Blytheville Ark</u>				25. DATE RECD. BY LOCAL REG. <u>12-27-61</u>		26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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

permit issued

Signed *John R. Stovall*

Licensed Embalmer No. *3130*

P. O. Address *Polyzese*

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.