

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047644  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE  
 Registration District No. 373 Primary Registration District No. 4575 Registrar's No. 58

AMENDED  
**FILED DEC 18 1961**

1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>HOAT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MARSHFIELD</b>		c. CITY OR TOWN <b>CRAIG MO</b> <input checked="" type="checkbox"/> Inside Limits Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HIS. E. Lucas</b>		d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>MELVIRA SINGLETON</b>			4. DATE OF DEATH Month Day Year <b>DEC 11 1961</b>		
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5. SEX <b>FEMALE</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>3-23-1879</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
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13a. FATHER'S NAME <b>EMANNAH WAARCE</b>	13b. MOTHER'S MAIDEN NAME <b>EMMALINE DAVIS</b>	14. NAME OF HUSBAND OR WIFE
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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) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>HESTER DUGAN MARSHFIELD</b>	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>PNEUMONIA</b>		
DUE TO (b) <b>SENILE CACHEXIA and GEN. DEBILITY</b>		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ARRESTED PULMONARY TUBERCULOSIS</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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 Month, Day, Year 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
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21. I attended the deceased from 5-13-61 to 12-11-61 and last saw <sup>(him)</sup> alive on 12-11-61  
 Death occurred at 950 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Robert J. Barcia, M.D.</b>	22b. ADDRESS <b>MARSHFIELD, MO</b>	22c. DATE SIGNED <b>12-13-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>FOOF</b>	23d. LOCATION (City, town, or county) (State) <b>HOAT CO MO</b>
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24. FUNERAL DIRECTOR <b>BARBER-EDWARDS MARSHFIELD</b>	25. DATE RECD. BY LOCAL REG. <b>12-12-61</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DATE AMENDED  
 ITEM NO. SHOULD READ  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

DEC 21 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 *R. W. Baker*

Licensed Embalmer No. 384

P. O. Address W. W. Brown

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.