

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005117

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 333 Primary Registration District No. 6113 Registrar's No. 17

FILED JAN 22 1962

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Benton</u>		Length of stay in lb <u>10 Yrs.</u>	c. CITY OR TOWN <u>Benton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Route 1</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ed</u> Middle <u>Foehand</u> Last <u>Foehand</u>			4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>62</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</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>10-10-1870</u>	9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>Searcy, Ark.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Ben Foehand</u>	13b. MOTHER'S MAIDEN NAME <u>—</u>	14. NAME OF HUSBAND OR WIFE <u>Ella Foehand</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Ella Foehand, Benton, Mo.</u> Address <u></u>
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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: IMMEDIATE CAUSE (a) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></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 (e)		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
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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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from First call after death and last saw him alive on .
Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Clayton Poe</u> (Degree or title) <u>Coroner</u>	22b. ADDRESS <u>Sikeston Mo.</u>	22c. DATE SIGNED <u>1-16-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>	23b. DATE <u>1-17-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset of Memory</u>	23d. LOCATION (City, town, or county) (State) <u>Sikeston Mo.</u>
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24. FUNERAL DIRECTOR <u>Dotson Funeral HOME, Sikeston, Mo.</u> ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>Jan 18-1962</u>	26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DATE AMENDED

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 Willie B. Davis

Licensed Embalmer No. 5129

P. O. Address Charleston TN

Permit issued

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.