

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-026586

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 151

FILED AUG 13 1962

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dunklin</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Kennett</u>                           |  | Length of stay in lb <u>7 wks.</u>   | c. CITY OR TOWN <u>Risco</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                     |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Dunklin County Memorial</u> |  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <u>Risco</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Bertha</u> Middle <u>Victoria</u> Last <u>McFatrige</u> |  |  | 4. DATE OF DEATH<br>Month <u>Aug.</u> Day <u>7</u> Year <u>1962</u> |  |  |
|---|--|--|---|--|--|

|                 |                               |   |                                       |                                       |                                |                              |
|-----------------|-------------------------------|---|---------------------------------------|---------------------------------------|--------------------------------|------------------------------|
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>cauc.</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 11, 1892</u> | 9. AGE (last birthday) <u>69 yrs.</u> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-----------------|-------------------------------|---|---------------------------------------|---------------------------------------|--------------------------------|------------------------------|

|  |                                   |   |  |
|--|-----------------------------------|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Stoddard County Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
|--|-----------------------------------|---|--|

|                                      |  |   |
|--------------------------------------|--|---|
| 13a. FATHER'S NAME <u>Lark Davis</u> | 13b. MOTHER'S MAIDEN NAME <u>Nancy Davis</u> | 14. NAME OF HUSBAND OR WIFE <u>O.T. McFatrige</u> |
|--------------------------------------|--|---|

|  |  |   |
|--|--|---|
| 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>Unknown</u> | 17. INFORMANT Address <u>O.T. McFatrige, Risco, Mo.</u> |
|--|--|---|

|   |   |  |
|---|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <u>Pulmonary Infection</u>  |   | <u>2 hours</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <u>Cubali from Phlebotomiasis in both legs</u> | <u>2 weeks</u>   |
|   | DUE TO (c) <u>Prolonged Bed rest after Surgery</u>        | <u>4 weeks</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a) <u>Cholecystectomy &amp; Splenectomy</u> ) |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><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<br>Hour . . . . .<br>a.m. . . . .<br>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 June 19, 1962 to Aug. 7, 1962 and last saw her <sup>her</sup> <sub>him</sub> alive on Aug. 7, 1962  
Death occurred at 7 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                                |                                 |
|---|--------------------------------|---------------------------------|
| 22a. SIGNATURE (Date or title) <u>Charles R. Clark M.D.</u> | 22b. ADDRESS <u>Kennett Mo</u> | 22c. DATE SIGNED <u>8/10/62</u> |
|---|--------------------------------|---------------------------------|

|   |                                |   |   |
|---|--------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Aug. 10, 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> | 23d. LOCATION (City, town, or county) <u>Malden Mo.</u> |
|---|--------------------------------|---|---|

|   |   |   |
|---|---|---|
| 24. FUNERAL DIRECTOR ADDRESS <u>Wekins And Sons, Parma, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>8-10-1962</u> | 26. REGISTRAR'S SIGNATURE <u>Gus H. [Signature]</u> |
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VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

AUG 21 1962

**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 Marsh Watkins

Licensed Embalmer No. 4717  
P. O. Address Deiter Mo.

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.