

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-047851

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. 267 Primary Registration District No. 3049 Registrar's No. 326
FILED DEC 19 1962

VS 300
Rev. 4/59

1 0781
2 0720
3 2
4 1
5 2
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7 1
8 0
9 9422.1
10
11
12 1-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Demiseat</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid,</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hayti</u>		Length of stay in 1b <u>3 Days</u>	c. CITY OR TOWN <u>Marston</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Demiseat County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>No</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Ellen Little</u>			4. DATE OF DEATH Month Day Year <u>12/ 7/62</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</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>11/12/1883</u>
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 <u>-- --</u>	9. AGE (last birthday) <u>79</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <u>Jackson Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Allen</u>		13b. MOTHER'S MAIDEN NAME <u>Unk.</u>	14. NAME OF HUSBAND OR WIFE <u>Tom Little</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>No.</u>	17. INFORMANT Address <u>Jack Little Conran, 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>Maxine CVF</u> DUE TO (b) <u>ACVD</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>25 yrs</u>
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 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 s.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>June 1959</u> to <u>7 Dec 62</u> and last saw her alive on <u>7 Dec 62</u>		Death occurred on _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>F. J. Smith M.D.</u> Degree of (fill in)		22b. ADDRESS <u>Pollogville, Mo</u>	22c. DATE SIGNED <u>10 Dec</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/9/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Park</u>	23d. LOCATION (City, town, or county) (State) <u>Near New Madrid, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Richards Funeral H omes New Madrid</u>		25. DATE RECD. BY LOCAL REG. <u>No. 12-12-62</u>	26. REGISTRAR'S SIGNATURE <u>Charlotte E. Sloan</u>

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 _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

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.