

MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028595

FILED VS SEP 9 1959

Registration District No. 91959/07 Primary Registration District No. 3019 Registrar's No. 168

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett</u> Length of stay in 1b <u>6 da</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dunklin Mem. Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u> c. CITY OR TOWN <u>Kennett</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>501 Wiggs St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H.</u> Last <u>Bostic</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>28</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>3-24-96</u>	9. AGE (last birthday) <u>63</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>Public accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Accountant</u>		11. BIRTHPLACE (City and state or country) <u>Malden, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Charles Hill Bostic</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Dunklin</u>	
14. NAME OF HUSBAND OR WIFE <u>Catherine Bostic</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Ray Shepard</u> Address <u>Kennett, 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>Intractable Pulmonary Edema</u> DUE TO (b) <u>Arteriosclerotic Heart Disease Severe</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 _____ a.m. _____ p.m. Month, Day, Year _____		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 _____		COUNTY _____ STATE _____	
21. I attended the deceased from <u>June 1959</u> to <u>August 28</u> and last saw him alive on <u>August 28, 1959</u> Death occurred at <u>August 28, 1959 - 9:10 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Les R. Gunnison Jr MD</u> (Degree or title)			22b. ADDRESS <u>Kennett Mo</u>		22c. DATE SIGNED <u>9-3-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>8-30-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dunklin Mem. Gardens</u>	
23d. LOCATION (City, town, or county) (State) <u>Kennett, Mo.</u>		24. FUNERAL DIRECTOR <u>Watkins & Sons</u> ADDRESS <u>Dexter, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-4-1959</u>	
26. REGISTRAR'S SIGNATURE <u>Paul Hubbard</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6901 8 13 1959

OCT 6 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
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 Dexter, 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.