

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-032069

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4205

FILED AUG 20 1965

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>ARKANSAS</u> b. COUNTY <u>BAXTER</u>                   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>KANSAS CITY</u>  |   | Length of stay in 1b<br><u>2 MOS.</u>   | c. CITY OR TOWN<br><u>MOUNTAIN HOME</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                      |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><u>DOA GENERAL HOSP.</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><u>404 SOUTH ST.</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>       |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>MINNIE JANE PRUITT</u>   |   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>AUGUST 8, 1965</u>  |
| 5. SEX<br><u>FEMALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-14-92</u>  |
| 9. AGE (last birthday)<br><u>73</u>  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>   | 11. BIRTHPLACE (City and state or country)<br><u>IUKA, ARKANSAS</u>  |
| 13a. FATHER'S NAME<br><u>MATTHEW ARNOLD</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>JANE UNKNOWN</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |   | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  |
| 17. INFORMANT<br>Address<br><u>ADA B. MC GOWAN 315 SO. INDIANA K. C., MO.</u>  |   | 14. NAME OF HUSBAND OR WIFE<br><u>LUNIE G. PRUITT</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Undetermined; probable coronary occlusion</u>                     |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>DOA</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |   |   |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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 a.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 _____, to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>C. B. Wheeler MD</u>  |   | 22b. ADDRESS<br><u>Crowner Jackson County Mo</u>  | 22c. DATE SIGNED<br><u>8-10-65</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>REMOVAL</u>  | 23b. DATE<br><u>8-9-1965</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>GALATIA CEMETERY</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>NORFORK, ARKANSAS</u>  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>C. H. BLACKMAN &amp; SON, INC. K. C., MO.</u>  |   | 25. DATE RECD. BY LOCAL REG.<br><u>8-9-65</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Beasie Smith</u>   |

USE BLACK INK OR TYPEWRITER RIBBON

**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 Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address H. C. 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.