

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK.  
FOR

FILED SEP 15 1994

MISSOURI DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

STATE FILE NUMBER

REGISTRATION DISTRICT NO.

REGISTRAR'S NUMBER 235021

DELAYED

124 - 36 - 049579

DO NOT WRITE  
ON THIS STUB

INSTRUCTIONS  
SEE OTHER SIDE  
AND HANDBOOK.

DECEDENT

affidavit from Moselle Fears Johnson  
Service Leachville Ark.  
notarized affidavit from  
notary Howard Johnson  
also a  
niece.

PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

Filed on the basis of  
Picture of tomb stone  
with a notarized state  
daughter in law and a

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Elbert Fears</b>		2. SEX <b>Male</b>	3. DATE OF DEATH (Month, Day, Year) <b>April 28, 1936</b>	
4. SOCIAL SECURITY NO. <b>None</b>	5a. AGE - Last Birthday (Years) <b>52</b>	5b. UNDER 1 YEAR MONTHS    DAYS	5c. UNDER 1 DAY HOURS    MINUTES	6. DATE OF BIRTH (Month, Day, Year) <b>5/29/1883</b>
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.		9a. PLACE OF DEATH (check only one; see instructions on other side) <b>HOSPITAL:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <b>OTHER:</b> <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (specify)		
9b. FACILITY NAME (If not institution, give street and number) <b>Route #1</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Arbyrd, Missouri</b>		9d. COUNTY OF DEATH <b>Dunklin</b>
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) <b>Married</b>	11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) <b>Claudia Simms</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>
13a. RESIDENCE - STATE <b>Missouri</b>	13b. COUNTY <b>Dunklin</b>	13c. CITY, TOWN, OR LOCATION <b>Arbyrd, Missouri</b>		13d. ZIP CODE <b>Route #1</b>
13e. STREET AND NUMBER <b>Route #1</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13g. YEARS AT PRESENT ADDRESS <input checked="" type="checkbox"/> Under 5 <input type="checkbox"/> 5-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20 or more	
14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:		15. RACE - American Indian, Black, White, etc. (Specify) <b>White</b>		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)    College (1-4 or 5+) <b>4</b>
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Moselle Fears Johnson</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>606 San Gabriel; St Louis, MO. 63125</b>		
20a. BURIAL, CREMATION, OTHER (Specify) <b>Burial</b>	20b. DATE OF DISPOSITION (Month, Day, Year) <b>4/29/36</b>	20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Leachville Cemetary</b>	20d. LOCATION - City or Town, State <b>Leachville, Arkansas</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH		22a. NAME AND ADDRESS OF FACILITY <b>HOWARD FUNERAL SERVICE P. O. Box 681 Leachville, AR 72438</b>		22b. FUNERAL ESTABLISHMENT LICENSE NUMBER <b>AR 144</b>
23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cerebral Hemorrhage</b>				Approximate Interval Between Onset and Death <b>2 days</b>
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):		
		c. DUE TO (OR AS A CONSEQUENCE OF):		
		d. DUE TO (OR AS A CONSEQUENCE OF):		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. List only one cause on each line.				
24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY <b>M</b>	27c. WAS INJURY ALCOHOL-RELATED? (Not known to decedent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.
27e. DESCRIBE HOW INJURY OCCURRED		27f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
27g. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)		28a. (Specify)		
28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) ▶		28c. DATE SIGNED (Month, Day, Year)	28d. TIME OF DEATH <b>M</b>	
29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print)		29b. MO. LICENSE NUMBER	30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input type="checkbox"/> Yes <input type="checkbox"/> No	
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		32. REGISTRAR'S SIGNATURE ▶		33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year)

## 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 \_\_\_\_\_

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.

### INSTRUCTIONS FOR SELECTED ITEMS

**Item 9a - Place of Death**

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

**Item 13a-g - Residence of Decedent**

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

**Item 23 - Cause of Death**

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the train of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

SEE EXAMPLES BELOW.

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
IMMEDIATE CAUSE <i>(Final disease or condition resulting in death)</i>	a. <u>Rupture of myocardium</u> DUE TO (OR AS A CONSEQUENCE OF):					Mins.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b. <u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF):					6 days
	c. <u>Chronic ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF):					5 years
	d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes, Chronic obstructive pulmonary disease, smoking</u>				24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year) _____	27b. TIME OF INJURY _____	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED _____	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify) _____			27g. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____			

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
IMMEDIATE CAUSE <i>(Final disease or condition resulting in death)</i>	a. <u>Cerebral laceration</u> DUE TO (OR AS A CONSEQUENCE OF):					10 mins.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b. <u>Open skull fracture</u> DUE TO (OR AS A CONSEQUENCE OF):					10 mins.
	c. <u>Automobile accident</u> DUE TO (OR AS A CONSEQUENCE OF):					10 mins.
	d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year) <u>11/15/85</u>	27b. TIME OF INJURY <u>1 p. m.</u>	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED <u>2-car collision-driver</u>	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify) <u>Street</u>			27g. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>Route 4, Jefferson City, Missouri</u>			