

FILED SEP 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29820

BIRTH NO. _____ REG. DIST. NO. 106 PRIMARY REG. DIST. NO. 4178 Registrar's No. 14

1. PLACE OF DEATH: a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>	
b. CITY OR TOWN <u>Holcomb</u>	c. LENGTH OF STAY (in this place) <u>43 years</u>	c. CITY OR TOWN <u>Holcomb</u>	<u>35</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Kate</u>	b. (Middle) <u>Luellen</u>	c. (Last) <u>Oakes</u>	4. DATE OF DEATH (Month) <u>Aug.</u> (Day) <u>21</u> (Year) <u>1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Feb. 16, 1870</u>	9. AGE (in years last birthday) <u>79</u>	UNDER 1 YEAR Months <u>6</u> Days <u>5</u>	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Invalid</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Thomas Lain</u>	13b. MOTHER'S MAIDEN NAME <u>Mary E. Black</u>	14. NAME OF HUSBAND OR WIFE <u>Henry Oakes</u>
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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. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Opal Pope</u>	ADDRESS <u>Holcomb Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Comp fracture femur</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Stroke apoplexy</u>		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Eye & Paralysis</u>			<u>334X</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) <u>Holcomb</u> (COUNTY) <u>Miss.</u> (STATE) _____
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21d. TIME OF INJURY (Month) <u>April</u> (Day) <u>6</u> (Year) <u>1948</u> (Hour) <u>7:30</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from April 6, 1948 to Aug 21, 1949, that I last saw the deceased alive on 8/17, 1949, and that death occurred at 1:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Wm. Cochran M.D.</u> (Degree or title)	23b. ADDRESS <u>Holcomb</u>	23c. DATE SIGNED <u>8/25/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 23, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Stanfield Cemetery</u>	24d. LOCATION (City, town, or county) <u>Clarkton</u> (State) <u>Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Sept. 6, 1949</u>	REGISTRAR'S SIGNATURE <u>J. G. Anderson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Landers Funeral Home</u> ADDRESS <u>Holcomb, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED SEP 15 194
District Health Office No.
District File Number 94-91
Date Filed

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
Student Embalmer

Signed *Christina M. Landess*

Licensed Embalmer No. *4227*

P. O. Address *Campbell, 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 this body is not embalmed, fact should be so stated above.