

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 21 1953

BIRTH NO. REG. DIST. NO. 240 PRIMARY REG. DIST. NO. 4358 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY New Madrid		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give township) Lilbourn		c. CITY (If outside corporate limits, write RURAL and give township) Lilbourn 0720	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			

3. NAME OF DECEASED (Type or Print) Walter	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH March 27 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 4 1879	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 2 Days 23	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Francisville, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Bill Graham	13b. MOTHER'S MAIDEN NAME Lydia Dicus	14. NAME OF HUSBAND OR WIFE Rellia Graham
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Rellia Graham-Lilbourn, Mo.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>General debilitation</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4347	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 26 Mar, 1953, to 26 Mar, 1953, that I last saw the deceased alive on 26 Mar, 1953 and that death occurred at 1:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Charles C. Ponder</u>	(Degree or title) M.D.	23b. ADDRESS New Madrid, Mo.	23c. DATE SIGNED 5 Apr. 53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-30-53	24c. NAME OF CEMETERY OR CREMATORY Mounds Park	24d. LOCATION (City, town, or county) (State) Lilbourn, Mo.
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DATE REC'D BY LOCAL REG. 4-6-53	REGISTRAR'S SIGNATURE <u>H.L. Ponder Deputy</u>	25. FUNERAL DIRECTOR'S SIGNATURE Ponder Funeral Home-Lilbourn, Mo.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Jones

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 *Homer L. Ponder*

Licensed Embalmer No. *3367*

P. O. Address *Tilbourn, 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.