

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16093

FILED JUN 8 1955

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 241 PRIMARY REG. DIST. NO. 4360 Registrar's No. 9

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>New Madrid</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)<br>a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Portageville</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Portageville</u>   |  |
| c. LENGTH OF STAY (in this place) <u>9 Years</u>   |  | 0 12 0   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Residence Portageville</u>                            |  | d. STREET ADDRESS (If rural, give location) <u>105 E. 5th St.</u>  |  |

|  |                           |                           |                        |   |
|--|---------------------------|---------------------------|------------------------|---|
| 3. NAME OF DECEASED<br>(Type or Print) | a. (First) <u>William</u> | b. (Middle) <u>Joseph</u> | c. (Last) <u>White</u> | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>May 19, 1955</u> |
|--|---------------------------|---------------------------|------------------------|---|

|                    |                               |   |                                      |   |   |  |
|--------------------|-------------------------------|---|--------------------------------------|---|---|--|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Feb. 8, 1882</u> | 9. AGE (In years last birthday) <u>73</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 4 WKS. Hours _____ Min. _____ |
|--------------------|-------------------------------|---|--------------------------------------|---|---|--|

|   |  |  |   |
|---|--|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | 11. BIRTHPLACE (State or foreign country) <u>Bonham, Texas</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
|---|--|--|---|

|   |  |   |
|---|--|---|
| 13a. FATHER'S NAME <u>William White</u> | 13b. MOTHER'S MAIDEN NAME <u>No Record</u> | 14. NAME OF HUSBAND OR WIFE <u>Victoria White</u> |
|---|--|---|

|  |                         |   |
|--|-------------------------|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____ |
|--|-------------------------|---|

|  |   |  |                                  |
|--|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cardiac decompensation</u>  |  | <u>36 hrs.</u>                   |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Ventricular Fibrillation</u><br>DUE TO (c) <u>Cardiac Asthma</u> |  | <u>6 weeks</u><br><u>6 years</u> |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |   |  |                                  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|--|

|  |  |   |
|--|--|---|
| 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) |
|--|--|---|

|  |  |                            |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from 1-12-1955, to 1-19-1955, that I last saw the deceased alive on 1-19-1955, and that death occurred at 2:30A m., from the causes and on the date stated above.

|  |                                       |                                 |
|--|---------------------------------------|---------------------------------|
| 23a. SIGNATURE <u>James O. Cameron</u> (Degree or title) <u>19-0</u> | 23b. ADDRESS <u>Portageville - Mo</u> | 23c. DATE SIGNED <u>5-21-55</u> |
|--|---------------------------------------|---------------------------------|

|   |                          |  |  |
|---|--------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>5/21/55</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u> |
|---|--------------------------|--|--|

|  |   |  |
|--|---|--|
| DATE REC'D BY LOCAL REG. <u>June 2, 1955</u> | REGISTRAR'S SIGNATURE <u>Ellen De Lisle</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Munnellee</u> ADDRESS <u>The Munnellee Funeral Chapel</u> |
|--|---|--|

DATE RECEIVED JUN 7 1955  
NEW MADRID CO. HEALTH CENTER

**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 \_\_\_\_\_

Licensed Embalmer No. 3851

P. O. Address Charleston

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.