

FILED APR 8 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9484

STATE FILE NUMBER

Registration District No. 239 Primary Registration District No. 5825 Registrar's No. 6Health,  
Welfare  
Public  
Service300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Como Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Catron, Mo. 0720</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 mile North Catron</u>		Length of stay in lb <u>2yrs.</u>	d. STREET ADDRESS <u>1 mile N. Catron</u>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Carpenter</u> Last <u>Carpenter</u>			4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1876</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u>11</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>West Point, Missi.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Bob Thomas</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>James Matthes</u> Address <u>Catron, Mo.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic changes, rt foot.</u> <u>331x</u>					INTERVAL BETWEEN ONSET AND DEATH
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 Hour _____ Month _____ Day _____ a. m. _____ p. m. _____					
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 <u>1946</u> to <u>1957</u> and last saw <sup>her</sup> <sub>him</sub> alive on _____ Death occurred at <u>7:00</u> p. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Louis Smith MD</u>			22b. ADDRESS <u>New Madrid Mo</u>		22c. DATE SIGNED <u>11 Mar 57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)	
<u>Burial</u>	<u>March 12, 57</u>	<u>Semmons Burial Park</u>	<u>Catron, Mo.</u>		
24. FUNERAL DIRECTOR <u>Ponder Funeral Home Lilbourn, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3/15/57</u>	26. REGISTRAR'S SIGNATURE <u>Dr. G. W. Heusted, MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

APR 3 1957

DATE RECEIVED APR 3 1957  
NEW MADRID CO. HEALTH CENTER

P. J. S.

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 David A. Ponder, Student Embalmer No. 596 working under my personal supervision.

Student David A. Ponder  
Signature of Student Embalmer

Signed Homer L. Ponder

Licensed Embalmer No. 336

P. O. Address Tilbourn

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.