

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34576

STATE FILE NUMBER

FILED OCT 15 1957

Registration District No. 381 Primary Registration District No. 4509 Registrar's No. 106

300
1-57
1050

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Humphreys</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Humphreys</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <u>20 yrs</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Robert McFarland Alexander</u>			4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1957</u>	
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>9-2-1856</u>	9. AGE (In years last birthday) <u>101</u>	IF UNDER 1 YEAR Months _____ Days _____	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>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Greenville Tenn.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Wm Alexander</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret McKee</u>	14. NAME OF HUSBAND OR WIFE <u>Laura Johnson Alexander</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)*	16. SOCIAL SECURITY NO. <u>4</u>	17. INFORMANT <u>W E Alexander</u> Address <u>Humphreys Mo</u>
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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>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Diastolic atherosclerosis</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>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Humphreys</u>	COUNTY <u>Sullivan</u>	STATE <u>Mo</u>
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21. I attended the deceased from <u>July 4 1957</u> to <u>Oct 6 1957</u> and last saw her alive on <u>10/6/57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Joseph S. Russell M.D.</u> (Degree or title)	22b. ADDRESS <u>Malibu, Mo</u>	22c. DATE SIGNED <u>10/6/57</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-8-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Humphreys Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Humphreys Mo</u>
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24. FUNERAL DIRECTOR <u>PK Raymond Galt</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>10-9-57</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Mary Beckett</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *PK Payne Jr*

Licensed Embalmer No. *3400*
P. O. Address *Salt*

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.