

pt. Health,
, & Welfare
S. Public
alth Service

THE DIVISION OF HEALTH OF MISSOURI

39406

FILED DEC 5 - 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 27

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Wayne</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Poplar Bluff (Rural)</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>Poplar Bluff Hos.</u>		Length of stay in lb <u>1 Day</u>	d. STREET ADDRESS (If outside, give location) <u>Williams Township</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Nothan</u> Last <u>Sutton</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1957</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8 1884</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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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>General</u>	11. BIRTHPLACE (City and state or country) <u>Annapolis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James Sutton</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Blankenship</u>	14. NAME OF HUSBAND OR WIFE <u>Dorothy Sutton</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. <u></u>	17. INFORMANT <u>Mrs Dorothy Sutton</u> Address <u>Williamsville 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>Cerebrovascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive Cerebrovascular Disease 443x</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 <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>	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 <u></u>	COUNTY <u></u>	STATE <u></u>
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21. I attended the deceased from <u>11-25-57</u> to <u>11-26-57</u> and last saw ^{him} alive on <u>11-26-57</u> Death occurred at <u>8:20 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. H. ...</u>	22b. ADDRESS <u>Poplar Bluff Mo</u>	22c. DATE SIGNED <u>11-27-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-29-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Near W. ... Mo.</u>
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24. FUNERAL DIRECTOR <u>William ...</u> ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>11/30/57</u>	26. REGISTRAR'S SIGNATURE <u>...</u>
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Securing the medical certification in the same manner required by 193.140 MOCS 1949.

487

RECEIVED

DEC 2 1957

BUTLER CO. HEALTH CENTER

FILE No. _____

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 Cader Funeral Home, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Kocher

Licensed Embalmer No. 3723

P. O. Address Piedmont, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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