

Health,
& Welfare
Public
Service

S. 300
v. 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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

67524-57

45175

STATE FILE NUMBER

FILED JAN 6 1958

Registration District No. 239 Primary Registration District No. 5825 Registrar's No. 23

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 Twsp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Catron</u>		Inside Limits 0720 Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 mi W of Catron</u>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>2 mi. W. of Catron</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Lee</u> Last <u>Pledger</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 11 1957</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>4</u> Days <u>1</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Parma, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Samuel Pledger Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Neyruth Clemon</u>					
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>None</u>		17. INFORMANT <u>Samuel Pledger Jr. - Catron, Mo.</u>			Address	
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>No. Medical Attendant, Child had</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cold. Found dead in bed</u> DUE TO (c) <u>Cause of death Unknown.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)).								INTERVAL BETWEEN ONSET AND DEATH <u>470X</u>	
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 _____ a. m. _____ p. m. Month _____ Day _____ Year _____									
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 _____, to _____ and last saw her/him alive on _____ Death occurred at <u>6:00</u> A. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Ed. Hedgkoth Coroner</u>				(Degree or title) <u>3</u>		22b. ADDRESS <u>New Madrid, Mo.</u>		22c. DATE SIGNED <u>Dec 13, 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>12-13-57</u>		<u>Simmons Cem.</u>		<u>Catron, Mo.</u>			
24. FUNERAL DIRECTOR <u>Ponder Funeral Home - Lilbourn, Mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12/14/57</u>		26. REGISTRAR'S SIGNATURE <u>Dr. Geo. Husted, MD</u>	

DATE RECEIVED DEC 24 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 Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Homer L. Ponder

Licensed Embalmer No. 336

P. O. Address Silbourn

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.