

Dr. *Robert B. [unclear]*  
FILED FEB 14 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

47454  
STATE LICENSE NUMBER  
Registrar's No. *6*

Registration District No. *272* Primary Registration District No. *4403*

1. PLACE OF DEATH a. COUNTY <i>Camden</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Camden</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Steele</i>		c. CITY OR TOWN <i>Steele</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <i>No Walnut</i>	
Length of stay in lb <i>30yr</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>Loy</i> Middle <i>Sucorgan</i> Last <i>Sucorgan</i>			4. DATE OF DEATH Month <i>12</i> Day <i>31</i> Year <i>57</i>		
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5. SEX <i>M</i>	6. COLOR OR RACE <i>Cal</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>unknown abt 79</i>	9. AGE (In years last birthday) <i>79</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Laborer</i>	11. BIRTHPLACE (City and state or country) <i>Calumet Miss.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13a. FATHER'S NAME <i>Heath Sucorgan</i>	13b. MOTHER'S MAIDEN NAME <i>Fannie Johnson</i>	14. NAME OF HUSBAND OR WIFE <i>[blank]</i>
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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) <i>NO</i>	16. SOCIAL SECURITY NO. <i>[blank]</i>	17. INFORMANT <i>Ruby Green</i>	Address <i>Hughes Ark</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary embolus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>Several years</i> <i>2 weeks</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Cardiac insufficiency</i>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>I.O.A.</i>	
	DUE TO (c) <i>Cardiac Decompensation</i>		

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.) <i>[blank]</i>
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20c. TIME OF INJURY Hour <i>[blank]</i> Month, Day, Year a.m. <i>[blank]</i> p.m. <i>[blank]</i>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>[blank]</i>	20f. CITY, TOWN, OR LOCATION <i>[blank]</i>	COUNTY <i>[blank]</i>	STATE <i>[blank]</i>
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21. I attended the deceased from <i>Nov. 1957</i> to <i>Dec. 57</i> and last saw her/him alive on <i>30 Dec 57</i> Death occurred at <i>7 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Robert B. [unclear]</i> (Degree or title) <i>D.O.</i>	22b. ADDRESS <i>Steele, Mo.</i>	22c. DATE SIGNED <i>Jan. 58</i>
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23a. BURIAL, CREMATION, OR REMOVAL (See 15f) <i>Buried</i>	23b. DATE <i>1-3-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Holly Grove</i>	23d. LOCATION (City, town, or county) (State) <i>Steele Mo</i>
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24. FUNERAL DIRECTOR <i>Herman Smith Co.</i>	ADDRESS <i>Steele Mo</i>	25. DATE RECD. BY LOCAL REG. <i>2-1-58</i>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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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

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2-51-58

FEB 13 1958

DEWISSET COUNTY HEALTH DEPARTMENT  
COURTHOUSE PHONE 79  
CARUTHERSVILLE, MO.

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 *[Handwritten Signature]* .....

Licensed Embalmer No. *4732* .....  
P. O. Address *Steele* .....

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.