

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004111

STATE FILE NUMBER

FILED FEB 13 1959

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 2-21-59

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Matthews</b> <i>0720</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 <b>Mo. Delta Comm. Hosp.</b>		Length of stay in lb <b>1 Day</b>	d. STREET ADDRESS (If outside, give location) <b>—</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JIM</b> Middle <b>LOWERY</b> Last <b>FORD</b>	4. DATE OF DEATH Month <b>2</b> Day <b>1</b> Year <b>1959</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-25-1876</b>	9. AGE (In years last birthday) <b>82</b>	FUNDER 1 YEAR Months <b>—</b> Days <b>—</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Little Rock, Arkansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Bill Ford</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Flora Masters</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT Address <b>Clara Sells, Matthews, Mo.</b>
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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) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary arteriosclerosis</b>	<b>?</b>
	DUE TO (c) <b>Gen. arteriosclerosis</b>	<b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>4201</b>		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 <b>—</b> Month, Day, Year <b>—</b> a.m. <b>—</b> p.m. <b>—</b>	20d. INJURY OCCURRED WHILE AT <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 <b>—</b> STATE <b>—</b>
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21. I attended the deceased from <b>Jan 30, 1959</b> , to <b>Feb 1, 1959</b> and last saw her alive on <b>Feb 1, 1959</b> Death occurred at <b>7:25 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Wm. C. Cutchers M.D.</b> (Degree or title)	22b. ADDRESS <b>Sikeston, Mo.</b>	22c. DATE SIGNED <b>2-5-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3 Feb. 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lathern Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>New Madrid, Missouri</b>
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24. FUNERAL DIRECTOR <b>Richards Undertaking Co.</b>	Address <b>New Madrid, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>2-5-59</b>	26. REGISTRAR'S SIGNATURE <b>Max Elmer Hunter</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Thomas L. Roberts* .....

Licensed Embalmer No. *4886* .....  
P. O. Address *New Madrid,* .....

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.

CO. FILE NO.