

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 715

FILED MAR 23 1959

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 715

1. PLACE OF DEATH a. COUNTY <b>Butler</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Butler</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Poplar Bluff 012 4/6</b> 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>VA Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>317 N. Broadway</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Archie Floyd</b>			4. DATE OF DEATH Month Day Year <b>March 4, 1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1887</b>
9. AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>11 7</b>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Groves County, Ky.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>John Floyd</b>	
13b. MOTHER'S MAIDEN NAME <b>Martha Smith</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Mrs. Willard Gillespie, Moline, Ill.</b>
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>Subdural Hemorrhage, left</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 to 4 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Skull Fracture, Occipital, bilateral</b>			<b>2 to 4 days</b>
DUE TO (c) <b>9035</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Fall on concrete walk.</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>Unknown 128</b>			
20d. INJURY OCCURRED WHILE AT WORK <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.) <b>Street</b>	20f. CITY, TOWN, OR LOCATION <b>Poplar Bluff, Butler, Mo.</b>	COUNTY STATE
21. I attended the deceased from <b>XXXXX</b> , to <b>XXXXX</b> and last saw her alive on <b>XXXXX</b> Death occurred at <b>3:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Grover Greer</i> <b>Grover Greer, Coroner</b>		22b. ADDRESS <b>Poplar Bluff, Mo.</b>	22c. DATE SIGNED <b>3-7-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-6-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cem. Vet s. plot</b>	23d. LOCATION (City, town, or county) (State) <b>Poplar Bluff, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Frank-Cotrell Poplar Bluff, Mo.</b>		25. DATE REC'D. BY LOCAL REG. <b>3/14/59</b>	26. REGISTRAR'S SIGNATURE <i>R. M. M. Tree</i>

 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

 Health, Welfare & Public Service  
 300  
 1-57  
 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 *Edgar W. Carr* .....  
Licensed Embalmer No. *3394* .....  
P. O. Address *10812 Bluff* .....

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.