Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008565
STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 137

1. PLACE OF DEATH
a. COUNTY Butler
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Poplar Bluff — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Doctors Hospital — Length of stay in lb 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Stoddard
c. CITY OR TOWN Dexter 1031 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Susan Middle Camilia Last McGarrity

4. DATE OF DEATH Month Day Year March 23, 1959

5. SEX female
6. COLOR OR RACE white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH July 22, 1882
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY housewife
11. BIRTHPLACE (City and state or country) Karo, Miss.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William J. Caldwell
13b. MOTHER'S MAIDEN NAME Paralee I. Bryant
14. NAME OF HUSBAND OR WIFE deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no x x x x x x x x
16. SOCIAL SECURITY NO. x x x x x
17. INFORMANT Leon McGarrity Address Dexter, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH 12
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) HCVD
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443 X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 0

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 June 1957, to 23 Mar 1959 and last saw her alive on 22 March 1959
Death occurred at 7.30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James H. Turner M.D.
22b. ADDRESS Dexter MO
22c. DATE SIGNED 3/24/1959

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 3-25-59
23c. NAME OF CEMETERY OR CREMATORY Dexter cemetery
23d. LOCATION (City, town, or county) (State) Dexter, Mo.

24. FUNERAL DIRECTOR Watkins & Sons ADDRESS Dexter, Mo.
25. DATE RECD. BY LOCAL REG. 3/28/59
26. REGISTRAR'S SIGNATURE [signature]

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Marsh Watkins

Licensed Embalmer No. 4717

P. O. Address Peter 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.