

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014335

STATE FILE NUMBER

DECEASED MAY 15 1959 Registration District No. 267 Primary Registration District No. 5905 Registrar's No. 67

300
1-57

1. PLACE OF DEATH a. COUNTY Pemisscott		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before) a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Portageville		c. CITY OR TOWN Frala	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wolf Byou R. 2		d. STREET ADDRESS (If outside, give location) 6 miles W. Portageville	

3. NAME OF DECEASED (Type or print) First William Middle White Last White			4. DATE OF DEATH Month May Day 10 Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 2, 1938	9. AGE (In years last birthday) 20	IF UNDER 1 YEAR Months 9 Days 8	IF UNDER 24 HRS. Hours 8 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) LaPlanto, Ark.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Laverne White	13b. MOTHER'S MAIDEN NAME Josie Ray	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name of unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 313 42 1245	17. INFORMANT Lavene White-Portageville, Route 3, Mo.	Address
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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) Asphyxiated		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 850X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) Boat Sunk
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20c. TIME OF INJURY Hour 4:40 PM Month 5 Day 10 Year 59	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, store, office bldg., etc.) Miss. River	20f. CITY, TOWN, OR LOCATION R. 2 Portageville, Pemisscott, Mo.	COUNTY 078	STATE
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21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) James G. Deburn	22b. ADDRESS Wardell, Mo.	22c. DATE SIGNED 5-11-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-12-59	23c. NAME OF CEMETERY OR CREMATORY Mounds Park Cemetery	23d. LOCATION (City, town, or county) (State) Lilbourn, Mo.
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24. FUNERAL DIRECTOR Ponder Funeral Home-Lilbourn, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 5/12/59	26. REGISTRAR'S SIGNATURE Valeria Popham
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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 *Harold D. Poole*

Licensed Embalmer No. *5030*

P. O. Address *Hickman, 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.