

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022330

STATE FILE NUMBER

86  
75

FILED JUL 1 1959

Registration District No. 240267 Primary Registration District No. 48593049 Registrar's No. 75

300  
1-56

health, Welfare Public Service  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Pemiscot</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hayti</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Marston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hayti Hosp.</u>		Length of stay in lb <u>12 hrs.</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Severe</u> Last <u>Brock</u>			4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9 1892</u>		9. AGE (In years last birthday) <u>67</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>6</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		100. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Searcy, Arkansas</u>	
13. FATHER'S NAME <u>Byrd Wortham</u>			14. MOTHER'S MAIDEN NAME <u>Mattie Carter</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William H. Brock-Marston, Mo</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> <u>congestive failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>hypertensive cardiovascular disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>12 hrs.</u> <u>15 yrs.</u>
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.) <u>443X</u>		
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>					
20d. INJURY OCCURRED WHILE AT WORK <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 STATE	
21. I attended the deceased from <u>April 59</u> to <u>15 June 59</u> and last saw her alive on <u>15 June 59</u> Death occurred at <u>10:15 P.M.</u> on the date stated above and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R. D. Smith M.D.</u> (Degree of title)			22b. ADDRESS <u>Putlogville, Mo.</u>		22c. DATE SIGNED <u>16 June 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-18-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Park</u>		23d. LOCATION (City, town, or county) (State) <u>Near Lilbourn, Mo.</u>
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>6-20-59</u>	26. REGISTRAR'S SIGNATURE <u>Valeria Popham</u>

JUN 29 1962

COURTHOUSE  
CARUTHERSVILLE, MD.  
PHONE 79

6983 1 70

APR 19 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate  
by me, or by ....., Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Homer L. Ponder*

Licensed Embalmer No. *339*

P. O. Address *Lilbou*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If  
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.