

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 4 1960

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Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 61D

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Butler				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler											
b. CITY (If outside corporate limits, give TOWNSHIP only) Poplar Bluff		Length of stay in 1b 1Hr		c. CITY OR TOWN Poplar Bluff		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Poplar Bluff, Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Baby Middle Bediant Last				4. DATE OF DEATH Month 12 Day 16 Year 59											
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-16-59		9. AGE (last birthday) 1Hr		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) Poplar Bluff, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Harvey Bediant				13b. MOTHER'S MAIDEN NAME Ima Halbrook				14. NAME OF HUSBAND OR WIFE Infant							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or if unknown) (If yes, give name dates of service)				16. SOCIAL SECURITY NO. -----				17. INFORMANT Harvey Bediant, Fisk, Mo.				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) Chronic disease of mother (The mother has advance cirrhosis of liver, acute + respiratory rareities) 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) PART II if deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown												INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)											
20c. TIME OF INJURY Hour s.m. p.m.		Month, Day, Year													
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 Dec 16 1959 to Dec 16 1959 and last saw ^{him} her alive on Dec 16 1959 . Death occurred at 4:45 p.m. ^{a.m.} on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) Harold O'Keefe M.D.						22b. ADDRESS 21502R Poplar Bluff, Mo.				22c. DATE SIGNED 12/17/59					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-17-59		23c. NAME OF CEMETERY OR CREMATORY Shain Memorial				23d. LOCATION (City, town, or county) (State) Butler, Co., Mo.							
24. FUNERAL DIRECTOR J.C. White				ADDRESS Fisk, Mo.				25. DATE RECD. BY LOCAL REG. 12/21/59		26. REGISTRAR'S SIGNATURE R. M. ...					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Not
Embalmed*

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.