

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS DEC 28 1959

'59 0 4 3 9 2 8

STATE FILE NUMBER

Registration District No. 228 Primary Registration District No. 200 Registrar's No. 1378

ENDED

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Arkansas</b> b. COUNTY <b>Jefferson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>1 day</b>		c. CITY OR TOWN <b>Pine Bluff</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>St. John's Hospital</b>			D.O.A. <b>D.O.A.</b>	d. STREET ADDRESS (If outside, give location) <b>55 Cypress</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>W.</b> Last <b>LEMONS</b>				4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 6, 1909</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - Dealer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Used Cars</b>	11. BIRTHPLACE (City and state or country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Hazel R. Lemons</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Mrs Hazel R Lemons, Pine Bluff, Ark.</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>Likely Coronary Occlusion</b> DUE TO (b) <b>Likely Coronary sclerosis</b> DUE TO (c) <b>UNATTENDED BY A PHYSICIAN</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <b>2:15 a.m.</b> 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 <b>Pine Bluff, Arkansas</b>		COUNTY	STATE
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____. Death occurred at <b>2:15 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>James R. Arnold M.D. Greene Co. Health Officer -</b>			22b. HEALTH OFFICE <b>Greene Co Health Dept - Springfield, Mo</b>			22c. DATE SIGNED <b>12-21-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Dec 18, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grayson Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pine Bluff, Arkansas</b>		
24. FUNERAL DIRECTOR <b>Jewell E. Windle</b>			ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-21-59</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bernard F. Wright

Licensed Embalmer No. 4293

P. O. Address Springfield

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.