

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 14 1960 243

59 0 4 4 8 6 8

STATE FILE NUMBER

Registration District No. Primary Registration District No. 4264 Registrar's No. 45

ENDED

1. PLACE OF DEATH a. COUNTY Newton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Benton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Stella		Length of stay in 1b 40 minutes	c. CITY OR TOWN Gentry Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardwell Memorial Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rural Route Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Marion Middle Franklin Last Downum			4. DATE OF DEATH Month December Day 7 Year 1959			
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1886	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Arkansas	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME John Downum	13b. MOTHER'S MAIDEN NAME Elizabeth Grammer	14. NAME OF HUSBAND OR WIFE Mary M. Downum
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. yes	17. INFORMANT Hospital Records 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) acute coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerotic heart disease		2 yrs.
	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 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
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

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
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21. I attended the deceased from **1957** to **Dec 7 59** and last saw her ^{her} _{him} alive on **Dec 7-59**
Death occurred at **7:58 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) D.D. Fountain D.O.	22b. ADDRESS noel moe	22c. DATE SIGNED Dec 19 59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/7/59	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Siloam Springs, Arkansas
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24. FUNERAL DIRECTOR Leon A. Wasson, Siloam Springs, Arkansas ADDRESS	25. DATE RECD. BY LOCAL REG. 12-30-59	26. REGISTRAR'S SIGNATURE Miedred Moherly
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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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert G. Wasson

Licensed Embalmer No. *Wh. 109*

P. O. Address *P.O. Box 29,*

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.