

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002633

FILED VS JAN 15 1960

Registration District No. 240 Primary Registration District No. 5827 Registrar's No. 2

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>New Madrid</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>Lewis Twp.</u>		Length of stay in 1b		c. CITY OR TOWN <u>Lilbourn</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>North Project</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>North Project</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Palmeter</u> Middle <u>Ward</u> Last				4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</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>4-7-1905</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Arkansas</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13a. FATHER'S NAME <u>Duff Calwe</u>			13b. MOTHER'S MAIDEN NAME <u>Fannie Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Thomas Ward</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 Address <u>Thomas Ward-Lilbourn, Mo.</u>				
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>Granuloid Cerebritis</u> <u>Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>		
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <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>Sept 59</u> to <u>Dec 59</u> and last saw ^{her} / _{him} alive on <u>15 Dec 1959</u> Death occurred at <u>3:20 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Charles C. Reeder M.D.</u> (Degree or title)				22b. ADDRESS <u>New Madrid Mo</u>			22c. DATE SIGNED <u>Jan 6</u> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-6-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sandhill</u>		23d. LOCATION (City, town, of county) (State) <u>Near New Madrid, Mo.</u>					
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>1-6-1960</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Ponder Deputy</u>			

BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION

JAN 15 1960

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 Harold H. Ponder

Licensed Embalmer No. 5030

P. O. Address Lillington, N.C.

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.