

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 11 1960

217

Primary Registration District No. 5787

Registrar's No. 40

-60-023869

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Charleston</u> Length of stay in 1b <u>28 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Route 1, Box 433</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miss.</u> c. CITY OR TOWN <u>Charleston</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Route 1, Box 433</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Manuel</u> Middle <u>Clemon</u> Last <u>Clemon</u>			4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</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>7/15/07</u>	9. AGE (last birthday) <u>52</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Holly Grove, Ark.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Wm. Clemon</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Robinson</u>		14. NAME OF HUSBAND OR WIFE <u>Margrett Clemon</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. <u>486-22-3612</u>	17. INFORMANT <u>Mrs. Margrett Clemon, R. 1, Charleston, 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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 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					INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>		
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>2:30 AM</u> to <u>12:30 PM</u> and last saw him alive on <u>6/24/60</u> Death occurred at <u>12:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>E. Charles Rowley MD</u>			22b. ADDRESS <u>Charleston, Mo.</u>		22c. DATE SIGNED <u>6/27/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/29/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		23d. LOCATION (City, town, or county) <u>Charleston, Mo.</u> (State)			
24. FUNERAL DIRECTOR <u>R. R. Sparkle</u> ADDRESS <u>Charleston, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-1-60</u>	26. REGISTRAR'S SIGNATURE <u>Sorathy B. Hathorn</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 11 1960

AUG 3 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 Oliver W. Johnson

Licensed Embalmer No. 4190

P. O. Address Charleston

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.