

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS JUN 28 1960

-60-023899

Registration District No. 240 Primary Registration District No. 5924 Registrar's No. 17

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>LaFont Township</u>		Length of stay in 1b <u>3 Yr.</u>		c. CITY OR TOWN <u>Marston, Missouri</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Marston, Mo.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>WILLIE</u> Middle <u>MAE</u> Last <u>ALLISON</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</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>12/5.1926</u>		9. AGE (last birthday) <u>33</u>		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) <u>House-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (City and state or country) <u>New Madrid Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Covie Tucker</u>				13b. MOTHER'S MAIDEN NAME <u>Gertrude Humphrey</u>				14. NAME OF HUSBAND OR WIFE <u>Richard Allison</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>None</u>		17. INFORMANT <u>Richard Allison Marston, 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>No Medical Attendant.</u> DUE TO (b) <u>Natural Causes</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
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 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 _____ a.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 _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>W. H. Hedgpeth</u> (Degree or title)						22b. ADDRESS <u>Corona New Madrid, Mo 6/15/60</u>			22c. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6/16/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fannie Powell Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>New Madrid Co., Mo.</u>						
24. FUNERAL DIRECTOR <u>RICHARD</u> ADDRESS <u>New Madrid, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>6-16-1960</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Ponder Deputy</u>							

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 Samuel H. Edgelyth

Licensed Embalmer No. 5188  
P. O. Address New Market

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.