

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030124

ENDED VS

SEP 13 1960

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 176

STATE FILE NUMBER

| | | | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dunklin</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett</u> | | Length of stay in 1b <u>days</u> | | c. CITY OR TOWN <u>Holcomb</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dunklin Co. Mem. Hosp.</u> | | | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel E. Wright</u> | | | 4. DATE OF DEATH Month Day Year <u>August 31, 1960</u> | | | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-17-72</u> | 9. AGE (last birthday) <u>82</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer, Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | | |
| 13a. FATHER'S NAME <u>Michael Wright</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Renfro</u> | | 14. NAME OF HUSBAND OR WIFE <u>Dell Hampton, Decd.</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>Unknown</u> | | 17. INFORMANT Address <u>Mrs. James Moore, Holcomb, 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>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Prostatic Hypertrophy</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 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 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 <u>Aug 25, 1960</u> to <u>Aug 31, 1960</u> and last saw him alive on <u>Aug 31-60</u> Death occurred at <u>Aug 31, 1960</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>George C. Cummings, M.D.</u> | | | | 22b. ADDRESS <u>Kennett, Mo</u> | | | | DATE SIGNED <u>9/1/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>9-2-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Stanfield Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Dunklin Co., Missouri</u> | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Irby Funeral Home, Rector, Ark.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>9-7-1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Earl J. Hunsaker</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 me
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Paul M. Biddle*

Licensed Embalmer No. 336

P. O. Address *Lecty Ave*

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.