

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041205

FILED VS. NOV 21 1960

43

Primary Registration District No. 3007

Registrar's No. 595

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>PEMISCOT</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>23 DAYS</b>		c. CITY OR TOWN <b>BRAGG CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>ROUTE ONE</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ZEBULON</b> Middle <b>WILLIAM</b> Last <b>STOUT</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>26</b> Year <b>1960</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-22-89</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>		11. BIRTHPLACE (City and state or country) <b>GREENFIELD, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>GRANVILLE STOUT</b>			13b. MOTHER'S MAIDEN NAME <b>ANN RAY</b>			14. NAME OF HUSBAND OR WIFE <b>IDA MAE STOUT</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>IDA MAE STOUT, RTE 1, BRAGG CITY, MO (Wife)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERIOSCLEROTIC HEART DISEASE.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2-3 Years</b>	
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		
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. <b>VA</b> attended the deceased from <b>October 3, 1960</b> to <b>Oct. 26, 1960</b> and last saw <b>her</b> <b>him</b> <b>alive on</b> _____ Death occurred at <b>9:28 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Robert S. Cohen</b> <b>ROBERT S. COHEN, M.D., Chief, Medical Svc. VA Hospital, Poplar Bluff, Mo.</b>				22b. ADDRESS		22c. DATE SIGNED <b>10/27/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>28 Oct 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Caruthersville Cemetery Caruthersville, Missouri</b>		23d. LOCATION (City, town, or county) (State)				
24. FUNERAL DIRECTOR <b>McDaniel Funeral Ser, Inc.</b>			ADDRESS <b>Kennett, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10/31/60</b>	26. REGISTRAR'S SIGNATURE <b>R. Mueller</b>			

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Tommy L. Roberts

Licensed Embalmer No. 4886

P. O. Address Keeneth

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.