

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041265

FILED VS NOV 21 1960

53

Primary Registration District No. 3010

Registrar's No. 452

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>CAPE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>CAPE</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CAPE GIRARDEAU</b>		Length of stay in 1b <b>4 yrs.</b>		c. CITY OR TOWN <b>CAPE GIRARDEAU</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>SOUTHEAST MO HOSP</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>180. 802 SPANISH</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MALE (#2 TWIN) ELFRANT</b>				4. DATE OF DEATH Month Day Year <b>Nov. 13 1960</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 13 1960</b>	9. AGE (last birthday) Months Days Hours Min. <b>4</b>	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>✓</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>✓</b>		11. BIRTHPLACE (City and state or country) <b>CAPE GIRARDEAU</b>		12. CITIZEN OF WHAT COUNTRY <b>✓</b>	
13a. FATHER'S NAME <b>BEAN HAO G. ELFRANT</b>			13b. MOTHER'S MAIDEN NAME <b>VIRGINIA L. MC AUSTER</b>			14. NAME OF HUSBAND OR WIFE <b>BERNARD ELFRANT</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>✓</b>			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>CAPE GIRARDEAU MO</b> <b>Bernard Elfrant</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>Premature Infant</b> DUE TO (b) <b>(Approx 6 mos. Gestation)</b> 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 checked="" 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 Month, Day, Year <b>10:35 AM 11-13-60</b>		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 <b>CAPE GIRARDEAU</b>		COUNTY <b>MO</b>		STATE <b>MO</b>		
21. I attended the deceased from <b>2:31 AM 11-13-60</b> to <b>7:03 AM 11-13-60</b> and last saw her alive on <b>11-13-60</b> Death occurred at <b>10:35 AM 11-13-60</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Chas. L. Herbert M.D.</b>				22b. ADDRESS <b>Cape Girardeau, MO</b>			22c. DATE SIGNED <b>11-16-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>6</b>		23b. DATE <b>11-14-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>UNION PARK GEN. CHAFFEE MO</b>		23d. LOCATION (City, town, or county) (State) <b>MO</b>			
24. FUNERAL DIRECTOR <b>STUBBS FUNERAL HOME MO</b>			ADDRESS <b>G CHAFFEE</b>		25. DATE RECD. BY LOCAL REG. <b>11-19-60</b>		26. REGISTRAR'S SIGNATURE <b>Karten</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Handwritten scribbles at the top of the page.*

**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.

*Not Embalmed*

Student \_\_\_\_\_ Signed \_\_\_\_\_

Signature of Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.