

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007815

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 121

FILED MAR 27 1961

1. PLACE OF DEATH a. COUNTY <u>Butler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carter</u>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u>		Length of stay in 1b <u>5 Days</u>		c. CITY OR TOWN <u>Hunter</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Poplar Bluff Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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 <u>Elizabeth</u> Middle <u>D.</u> Last <u>Stone</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</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>4-13-84</u>	9. AGE (last birthday) <u>76</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>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Carter Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Day</u>			13b. MOTHER'S MAIDEN NAME <u>Coaley Crites</u>		14. NAME OF HUSBAND OR WIFE <u>S.M. Stone</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>S.M. Stone, Hunter, 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>Pellagra Pellagra</u> DUE TO (b) <u>Jaundice</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 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>3-1-1961</u> to <u>3-7-1961</u> and last saw her/him alive on <u>3-7-61</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dr. Kenneth D. Poplar Bluff Mo</u>				22b. ADDRESS		22c. DATE SIGNED <u>3-11-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Mar. 10-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Scott Cemetery</u>		23d. LOCATION (City, town, or county) <u>Carter Co.</u>		(State) <u>Mo.</u>
24. FUNERAL DIRECTOR <u>Seaton Perwit Van Buren Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>3/14/61</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

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 Seaton Pewitt

Licensed Embalmer No. 2287

P. O. Address Van Buren Mo

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.