

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-009892

STATE FILE NUMBER

Registration District No. 239 Primary Registration District No. 5825 Registrar's No. 8

AMENDED FILED APR 3 1961

1. PLACE OF DEATH a. COUNTY NEW MADRID				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY New Madrid									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN COMO		Length of stay in 1b 5 Minutes		c. CITY OR TOWN Parma		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2 1/2 Mi, E. of Malden.			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2 1/2 Mi, S. W. Parma, Mo.		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First ALBERTIA Middle MOORE Last				4. DATE OF DEATH Month MARCH Day 16 Year 1961									
5. SEX FEMALE		6. COLOR OR RACE Colored		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-3-28		9. AGE (last birthday) 32		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) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Leland Miss		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME Jessie Jackson				13b. MOTHER'S MAIDEN NAME Louise Jackson				14. NAME OF HUSBAND OR WIFE Willie Moore					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Address Willie Moore, R-2, Box 339, Parma, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: PART I. IMMEDIATE CAUSE (a) Fractured Skull, Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Punctured right lung. DUE TO (c) _____										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 checked="" 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.) Auto Accident									
20c. TIME OF INJURY Hour 5:30 a.m. p.m. Month, Day, Year 3-16-61		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.) Highway 62		20f. CITY, TOWN, OR LOCATION New Madrid		COUNTY Mo.		STATE			
21. I attended the deceased from _____, to _____ and last saw him alive on _____ Death occurred at 5:30 P. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
27a. SIGNATURE (Degree or title) Dr. Hedgcock Coroner				22b. ADDRESS New Madrid, Mo.				22c. DATE SIGNED 3/21/61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-20-61		23c. NAME OF CEMETERY OR CREMATORY Sweet Home		23d. LOCATION (City, town, or county) (State) New Madrid County Mo.						
24. FUNERAL DIRECTOR ADDRESS Day & Knight F.S. Malden, Mo.					25. DATE RECD. BY LOCAL REG. 3/24/61		26. REGISTRAR'S SIGNATURE Dr. Geo. W. Husted, M.D.						

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 J. J. Schuman
Licensed Embalmer No. 4086

P. O. Address Malden

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.