

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012839
STATE FILE NUMBER

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 50
FILED MAY 15 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CAPE GIRARDEAU	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 37 DAYS	c. CITY OR TOWN JACKSON Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 704 HOPE STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First COBIE Middle FRANKLIN Last SIDES			4. DATE OF DEATH Month APRIL Day 25 Year 1961
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-7-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILWAY LABORER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	9. AGE (last birthday) 71 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) ALLENVILLE, MISSOURI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME FRANK SIDES		13b. MOTHER'S MAIDEN NAME MOLLIE RENFRO	14. NAME OF HUSBAND OR WIFE MORA SIDES (DECEASED)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE.			INTERVAL BETWEEN ONSET AND DEATH 4LB 3 Weeks
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.) VA	20f. CITY, TOWN, OR LOCATION March 19, 1961 to April 25, 1961	COUNTY _____ STATE _____
21. attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 4:05 AM _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert S. Cohen ROBERT S. COHEN, M.D., Chief, Medical Svc.		22b. ADDRESS VA Hospital, Poplar Bluff, Mo.	22c. DATE SIGNED 5/2/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/29/61	23c. NAME OF CEMETERY OR CREMATORY Fairmont Cemetery	23d. LOCATION (City, town, or county) (State) Cape Girardeau, Mo.
24. FUNERAL DIRECTOR L. P. Sparks ADDRESS Cape Girardeau, Mo.		25. DATE RECD. BY LOCAL REG. 5-7-1961	26. REGISTRAR'S SIGNATURE Helma Pruban

MAY 15 1961

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 Luigi Robert Jones

Licensed Embalmer No. 5132

P. O. Address Charleston

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.