MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-016717

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4352 STATE FILE NUMBER

FILED MAY 10 1962

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE La. b. COUNTY Tensas Parrish

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b

c. CITY OR TOWN Newellton — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) City Hospital #1 — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) Route 1- Box 97 — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Lizzie Middle Darden Last

4. DATE OF DEATH Month 4 Day 24 Year 62

5. SEX Female

6. COLOR OR RACE Colored

7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ Separated

8. DATE OF BIRTH 1-31-04

9. AGE (last birthday) 58

IF UNDER 1 YEAR Months 2 Days 23 — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Mississippi

12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME Simon Early

13b. MOTHER'S MAIDEN NAME Octavia Rose

14. NAME OF HUSBAND OR WIFE Separated

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Bifer Brown Address 905 A. No. Vanderventer

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Myocarditis;

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arachnoiditis.

DUE TO (c) 422.2

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. ☐ Yes ☐ No ☒ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 _____ to _____ and last saw her/him alive on _____
Death occurred at 855 p.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Helen L. Taylor, Coroner

22b. ADDRESS 1300 Clark Ave

22c. DATE SIGNED 4-27-62

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY Burns

23d. LOCATION (City, town, or county) (State) Newellton Louisiana

24. FUNERAL DIRECTOR Ellis Funeral Home ADDRESS 2820 Stoddard St.

25. DATE RECD. BY LOCAL REG. APR 27 1962

26. REGISTRAR'S SIGNATURE Carl Smith. M.D.

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 Fulton E. Cuckin

Licensed Embalmer No. 4198

P. O. Address St Louis 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.