

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-026174

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 917

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 8 1962	
1. PLACE OF DEATH a. COUNTY BUTLER b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF Length of stay in 1b 15 DAYS c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION VA. HOSPITAL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARK. b. COUNTY LAWRENCE c. CITY OR TOWN HOXIE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) GEN DEL Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle WALKER Last BILLETT	
4. DATE OF DEATH Month JULY Day 5 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-26-84
9. AGE (last birthday) 77 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) LABORER	10b. KIND OF BUSINESS OR INDUSTRY GENERAL LABORER
11. BIRTHPLACE (City and state or country) EVANSVILLE IND	
12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME ANDERSON BILLETT	13b. MOTHER'S MAIDEN NAME UNKNOWN
14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW1	
16. SOCIAL SECURITY NO. UNKNOWN	
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) ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) ARTERIOSCLEROSIS OBLITERANS DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) DIABETES MELLITUS	
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 _____ Month, Day, Year _____ a.m. p.m.	
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. VA attended the deceased from June 21, 1962 to July 5, 1962 and last seen alive on 08:25AM Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Robert S. Cohen (Degree or title) ROBERT S. COHEN, M.D. Chief, Med. Svc.	
22b. ADDRESS VA. HOSPITAL, POPLAR BLUFF, MO.	
22c. DATE SIGNED 7-11-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 7-8-1962	
23c. NAME OF CEMETERY OR CREMATORY Lawrence Memorial Cem. Walnut Ridge, Ark.	
23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR M.C. McNeble ADDRESS Pocahontas, Ark.	
25. DATE RECD. BY LOCAL REG. 8-4-1962	
26. REGISTRAR'S SIGNATURE Thelma Graham	

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

VS 300 Rev. 4/59
 0129
 8030
 3
 4 0
 5 2
 6
 7 1
 8 2
 94200
 10
 11
 12 5-0
 13 1-1

USE BLACK INK OR TYPEWRITER RIBBON

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 M. C. McNeill

Licensed Embalmer No. 680 (Ark.)
P. O. Address Doakenton, Ark.

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.