

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004800

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 233 Primary Registration District No. 3074 Registrar's No. 41

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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| FILED FEB 11 1963  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Scott</b><br>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b> Length of stay in Tn <b>4 hours</b><br>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>No. Delta Community Hosp.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b><br>c. CITY OR TOWN <b>East Prairie</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/><br>d. STREET ADDRESS (If outside, give location) <b>Rt. # , Box 392</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Calvin</b> Middle <b>Belle</b> Last <b>Belle</b>   | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>4</b> Year <b>1963</b>   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>Colored</b>  |
| 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <b>Baby</b>  | 8. DATE OF BIRTH <b>11/4/62</b>  |
| 9. AGE (last birthday) <b>3</b> Months <b>3</b> Days   | 10. IF UNDER 1 YEAR IF UNDER 24 HR Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----  | 10b. KIND OF BUSINESS OR INDUSTRY -----  |
| 11. BIRTHPLACE (City and state or country) <b>East Prairie, Mo.</b>  | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>   |
| 13a. FATHER'S NAME <b>Tommie Lee Belle</b>   | 13b. MOTHER'S MAIDEN NAME <b>Jeanette Miller</b>   |
| 14. NAME OF HUSBAND OR WIFE -----  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) -----  | 16. SOCIAL SECURITY NO. -----  |
| 17. INFORMANT <b>Tommie Lee Belle, R. 2, East Prairie, Mo.</b>   | Address -----  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO (b) -----<br>DUE TO (c) -----<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown<br>INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. I attended the deceased from <b>5<sup>00</sup> A.M. 2/4/63</b> to <b>9<sup>00</sup> A.M. 2/4/63</b> and last saw her/him alive on <b>2-4-63</b><br>Death occurred at <b>9<sup>00</sup> A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.   |  |
| 22a. SIGNATURE <b>G.S. Clarke M.D.</b> (Degree or title)   | 22b. ADDRESS <b>Sikeston Mo</b>  |
| 22c. DATE SIGNED <b>2-4-63</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE <b>2/6/63</b>  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>   |  |
| 23d. LOCATION (City, town, or county) (State) <b>Charleston, Missouri</b>  |  |
| 24. FUNERAL DIRECTOR <b>L.R. Sparks</b> ADDRESS <b>Charleston, Mo.</b>   | 25. DATE RECD. BY LOCAL REG. <b>2-8-1963</b>   |
| 26. REGISTRAR'S SIGNATURE <b>Jeanette Waldman R.R.</b>   |  |

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Edmund McMillan

Licensed Embalmer No. 4695

P. O. Address Charleston, W. Va.

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.