

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007750

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 240 Primary Registration District No. 4358 Registrar's No. 9

FILED MAR 5 1963

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| VS 300 | DATE AMENDED |
| Rev. 4/59 | |
| 1 0720 | INSTEAD OF |
| 2 0720 | |
| 3 | DOCUMENT |
| 4 3 | |
| 5 2 | MEDICAL CERTIFICATION |
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| 7 1 | BY AFFIDAVIT OF |
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| 9 6000 | SHOULD READ |
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| 11 | ITEM NO. |
| 12 90-0 | |
| 13 4-0 | TYPewriter RIBBON |
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|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>New Madrid</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lilbourn</u> | | c. CITY OR TOWN <u>Lilbourn</u> | |
| Length of stay in '1b' <u>2 years</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Charlotte St.</u> | | d. STREET ADDRESS (If outside, give location) <u>Charlotte St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Hamby</u> Last <u>Hamby</u> | | 4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>1963</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-12-96</u> |
| 9. AGE (last birthday) <u>66</u> | | IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pensioner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (City and state or country) <u>Morrilton, Arkansas</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Sidney McDaniels</u> | | 13b. MOTHER'S MAIDEN NAME <u>Alice Sexton</u> | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date) <u>No</u> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Thado Brockington-Lilbourn, Mo.</u> Address | |
| 18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelonephritis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 1/2</u> |
| 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). <u>Hypertensive Cardiovascular disease</u> | | | 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 checked="" 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 <u>Dec 1961</u> to <u>Feb 23 1963</u> and last saw her alive on <u>Feb 23 1963</u> . Death occurred at <u>4:40 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Deceased or Title) <u>Daniel R. Heasley</u> | | 22b. ADDRESS <u>Jac. Brown Mo 4-2-63</u> | |
| 22c. DATE SIGNED (State) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>3-3-1963</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Sannie Powell Cem.</u> | | 23d. LOCATION (City, town, or county) <u>Near New Madrid, Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo;</u> | | 25. DATE RECD. BY LOCAL REG. <u>3-2-1963</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Charles Simpson by H. J. Ponder</u> | | | |

MAR 2 1963

Delivered to Doctor 2-25-63

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

Ernest H. Ponder

Licensed Embalmer No. 5030

P. O. Address Lithonia, 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.