

# R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028598

STATE FILE NUMBER

FILED VS. AUG 26 1959

107

Primary Registration District No. 3019

Registrar's No. 152

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dunklin</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett, Mo.</u> Length of stay in lb <u>12 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fressnell Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dunklin</u> c. CITY OR TOWN <u>Kennett</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>701 S. Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> First <u>Ernest</u> Middle <u>Emery</u> Last <u>Counts</u> (Type or print)				<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>14</u> Year <u>1959</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3-7-1916</u>		<b>9. AGE</b> (last birthday) <u>43</u>		<b>IF UNDER 1 YEAR</b> Months <u>4</u> Days <u>27</u> Hours <u></u> Min. <u></u>		<b>IF UNDER 24 HR</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (City and state or country) <u>Success, Ark.</u>				<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>			
<b>13a. FATHER'S NAME</b> <u>Jasper L. Counts</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>Emma Elizabeth Dennis</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>Jewell Marget Counts</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>491-18-5060</u>				<b>17. INFORMANT</b> <u>Mrs. Jewell Counts-Kennett</u> Address <u>Mo.</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>												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) <u>Carcinoma</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					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>															
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)				<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>					
<b>21. I attended the deceased from</b> <u>8-2-59</u> <b>to</b> <u>8-14-59</u> <b>and last saw him alive on</b> <u>8-14-59</u> <b>Death occurred at</b> <u>approximately 3:25p</u> <b>on the date stated above, and to the best of my knowledge, from the causes stated.</b>															
<b>22a. SIGNATURE</b> <u>L.C. Wilson M.D.</u> (Degree or title)						<b>22b. ADDRESS</b> <u>Kennett, Mo.</u>				<b>22c. DATE SIGNED</b> <u>8-17-59</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>8-16-1959</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Ridge</u>				<b>23d. LOCATION</b> (City, town, or county) <u>Kennett</u> (State) <u>Mo.</u>							
<b>24. FUNERAL DIRECTOR</b> <u>McDaniel Funeral Ser., Kennett, Mo.</u> ADDRESS <u></u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>8-18-1959</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Earl Husband</u>									

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1 AUG 26 1959

COUNTY FILE NUMBER 859-254

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Tommy L. DeLuca

Licensed Embalmer No. 4886

P. O. Address Kennett

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.