

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0024353

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 232 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

JNF FILED 23 64

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1 0941						
2 0942						
3						
4 1						
5 3						
6						
7 0						
8 2						
9 4/201						
10						
11						
12 1-0						
13 1-0						
USE BLACK INK OR TYPEWRITER RIBBON	ITEM NO.	SHOULD READ				

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u> Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u> c. CITY OR TOWN <u>Flat River</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>Bonne Terre Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>10 - Chestnut, St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>Stella</u> Middle <u>--</u> Last <u>Jinkerson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15th.</u> Year <u>1964</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Aug. 9th. 1891 - 72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <u>St. Francois Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Forchee</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Doggett</u>	
14. NAME OF HUSBAND OR WIFE <u>John Jinkerson (Dec)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>8</u>		17. INFORMANT Address <u>Rt. 2</u> <u>Albert Forchee, Bonne Terre, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>unknown cause</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>How previous myocardial infarction</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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>June 13, 1964</u> to <u>June 15, 1964</u> and last saw her alive on <u>June 15, 1964</u> Death occurred at <u>9:15P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. L. Foster</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Desloge, Missouri</u>	22c. DATE SIGNED <u>6-17-64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/18/1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Adams Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Francois Co. Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>C.Z. Boyer & Son Desloge, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>June 17, 1964</u>	26. REGISTRAR'S SIGNATURE <u>Arthur Desloge</u>

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 B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Dealoge, Missouri

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.