

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0045770

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

DEFILED 09 64

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 472

VS 300  
Rev. 4/59

1 0941  
2 0940  
3  
4 0  
5 2  
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7 0  
8 1  
9 46700  
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12 1-0  
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		Length of stay in lb <u>9 hrs.</u>	c. CITY OR TOWN <u>Esther</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Henry</u> Last <u>Counts</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1964</u>		
5. SEX <u>Male</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>5/13/1869</u>	9. AGE (last birthday) <u>95</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Sta. Genevieve, Mo</u>	
10c. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Martin N. Counts</u>		13b. MOTHER'S MAIDEN NAME <u>Lulu Melvina Thurman</u>	
13c. NAME OF HUSBAND OR WIFE <u>Deceased</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Joyce Post Greenwood, Miss.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Hypertension, exposure to Septicemia.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>unk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Septicemia.</u>					<u>unk.</u>
DUE TO (c) <u>Pneumonia Rt. upper lobar.</u>					<u>unk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis</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 checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>1-Dec-64</u> to <u>1-Dec-64</u> and last saw <u>him</u> live on <u>1-Dec-64</u> . Death occurred at <u>2:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Stanley J. Hardy M.D.</u>			22b. ADDRESS <u>Desloge, Mo</u>		22c. DATE SIGNED <u>12/4/64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/4/1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Francois Co. Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Murphy L. Sparks Flat River, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Dec. 4, 1964</u>	26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>	

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JAN 19 1965  
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**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 Murphy L. Sparks

Licensed Embalmer No. 4236

P. O. Address Hot River, 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.