

ARKANSAS DEPARTMENT OF HEALTH  
Division of Vital Records  
CERTIFICATE OF DEATH

218282

PE/PRINT  
IN  
MANENT  
ACK INK  
FOR  
DUCTIONS  
HANDBOOK

DECEDENT

SEE INSTRUCTIONS  
ON OTHER SIDE

PARENTS

INFORMANT

DISPOSITION

SEE INSTRUCTIONS  
ON OTHER SIDE

CAUSE OF  
DEATH

CERTIFIER

REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last) Altha Elizabeth Davis					2. SEX female	3. DATE OF DEATH (Month, Day, Year) Oct. 25, 1993	
4. SOCIAL SECURITY NUMBER 431 78 1852		5a. AGE - Last Birthday (Years) 95	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Month, Day, Year) Mar. 29, 1898	7. BIRTHPLACE (City and State or Foreign Country) Christopher, IL	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) no			9a. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
9b. FACILITY NAME (If not institution, give street and number) North Arkansas Medical Center				9c. CITY, TOWN, OR LOCATION OF DEATH Harrison		9d. COUNTY OF DEATH Boone	
10. MARITAL STATUS - Married Never Married, Widowed, Divorced (Specify) widowed		11. SURVIVING SPOUSE (If wife, give maiden name) na		12a. DECEDENT'S USUAL OCCUPATION (Specify kind of work done during most of working life. Do not use retired.) Postmaster		12b. KIND OF BUSINESS/INDUSTRY Post Office	
13a. RESIDENCE - STATE AR		13b. COUNTY Boone		13c. CITY, TOWN, OR LOCATION Harrison		13d. STREET AND NUMBER Rt 2 Box 41 B	
13e. INSIDE CITY LIMITS? (Yes or No) no		13f. ZIP CODE 72601		14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify		15. RACE - American Indian, Black, White, etc. (Specify) white	
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5-+) 12 4							
17. FATHER'S NAME (First, Middle, Last) William Houston Frye				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ellen Lentz			
19a. INFORMANT'S NAME (Type/Print) Irene Bradford				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 741 Kimberling City, MO 65686			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)							
20b. DATE OF DISPOSITION (Month, Day, Year) Oct. 29, 1993		20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Bellefonte Cemetery			20d. LOCATION - City or Town, State Bellefonte, AR		
21a. SIGNATURE OF EMBALMER <i>Steven K. Johnson</i>		21b. LICENSE NUMBER 1819		22a. NAME AND ADDRESS OF FUNERAL HOME Holt Memorial Chapel 1904 Capps RD Harrison, AR		22b. LICENSE NUMBER 123	
23. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>CHF</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death <i>1 hr</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24. WAS AN AUTOPSY PERFORMED? (Yes or No) no		25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Pending Investigation				27. DATE OF INJURY (Month, Day, Year)		28. TIME OF INJURY M	
29. INJURY AT WORK? (Yes or No)							
30. DESCRIBE HOW INJURY OCCURRED							
31. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				32. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
33. TIME OF DEATH 1813 p.m.		34. DATE PRONOUNCED DEAD (Month, Day, Year) Oct. 25, 1993			35. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No) no		
36. MEDICAL EXAMINER or CORONER Only On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner as stated. Signature and Title → <i>[Signature]</i>						37. DATE SIGNED (Month, Day, Year) Oct 27, 1993	
38. CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. Signature and Title → <i>[Signature] M.D.</i>						39. DATE SIGNED (Month, Day, Year) Oct 27, 1993	
40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) Thomas S. Leslie, M.D., 306 N. Chestnut, Harrison, AR 72601							
41. REGISTRAR'S SIGNATURE <i>[Signature]</i>						42. DATE FILED (Month, Day, Year) OCT 27, 1993	

REV 05-89 VR-2

THIS IS A CERTIFIED COPY OF AN ORIGINAL DOCUMENT

THIS IS TO CERTIFY, that the above is an exact reproduction of the original death certificate, which is in my possession this date and of which I have the authority to issue under Act 120 of 1981. IN TESTIMONY WHEREOF, witness my hand and seal of office at

(SEAL)

Date 10-27-93

County Registrar [Signature]