

1939 JUL 24

Dup of 11662-39

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

22800
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 608
(b) Township West Primary Registration District No. 4367
(c) City Canalou (d) Street No. 4357 Registered No. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Allen Henderson Sexton

(a) Residence, No. Canalou, Missouri St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clara Ann Sexton 1871

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 5, 1859

7. AGE YEARS 79 MONTHS 6 DAYS 7 IF LESS THAN 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Crittenden County
(STATE OR COUNTRY) Kentucky

FATHER 13. NAME Allen Sexton

14. BIRTHPLACE (CITY OR TOWN) Simpson County
(STATE OR COUNTRY) Tennessee

MOTHER 15. MAIDEN NAME Marilyn Smith

16. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

17. INFORMANT Less Sexton
(ADDRESS) Sikeston, Missouri

18. BURIAL, CREMATION OR REMOVAL
PLACE Sikeston City Cemetery DATE April 16, 1939
Sikeston, Missouri

19. FUNERAL DIRECTOR (NAME) H. J. Welsh
(ADDRESS) Sikeston, Missouri

20. FILED July 20, 1939 Mrs. John Parrish
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 14, 1939

22. I HEREBY CERTIFY, That I attended deceased from 14-5, 1939, to 4-15, 1939.
I last saw him alive on 4-15, 1939. Death is said to have occurred on the date stated above, at 7:30 P.M.
The principal cause of death and related causes of importance were as follows:

Endocarditis, perhaps twenty five years
Arterio-sclerosis, maybe forty years
Date of onset undetermined

Other contributory causes of importance:
Arterio-sclerosis, maybe forty years

Name of operation none Date of _____
What test confirmed diagnosis? no Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury _____, 19____
Where did injury occur? none
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none
Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? none
If so, specify _____
(Signed) C. H. Pease, M. D.
(Address) Marchessaux, Missouri

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 Harvey S. John

Registered Apprentice No. 3704, working under my personal supervision.

Signed H. J. Welsh
Licensed Embalmer No. 774
P. O. Address Sikeston

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

22800

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 603
 (b) Township West Primary Registration District No. 4357 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Allen Henderson Sexton

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 5 - 1871

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>67</u>	<u>11</u>	<u>9</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19. _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 7-20, 1939 Mrs. John Parrish Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-14, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the _____ stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____.

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify C. H. Pease, M. D.
 (Signed) _____ (Address) morehouse mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

