

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **821**

Primary Registration District No. **6072**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Scott**
(b) City or town **Rural Route 3**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **Four Years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Scott**
(c) City or town **Sikeston, R.F.D. 3**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Suzan Aday**

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **E F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Wade Aday** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Nov. 14 1853**
(Month) (Day) (Year)

8. AGE: Years **87** Months **-** Days **11** If less than one day hr. _____ min.

9. Birthplace **Witt Springs Ark.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business _____

12. Name **Fed Cossey**

13. Birthplace **Unknown Tenn.**
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Ann (Unknown)**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Amos Cossey**
(b) Address **Sikeston, Mo. #3 Box 299**

17. (a) **Burial in** (b) Date thereof **11 25 40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **McMullin**

18. (a) Signature of funeral director **John Althoff**

(b) Address **Sikeston, Missouri**

19. (a) **12-6-1940** (b) **W. H. Alsewell**
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

9

742
Am. Davis
Morhouse Mo.
12-24

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **25**
year **1940** hour **12** minute **35 A.M.**

21. I hereby certify that I attended the deceased from **Nov 24**
1940 to **Nov 24**, 19 **40**
that I last saw her alive on **11/24**, 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic pleuritic heart disease**

Due to _____

Due to **Chronic pleuritic heart disease**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Am. Davis** (M. D. or other) **MD**

Address **Morhouse Mo.** Date signed **12-24**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 2

District File Number 1240-179

Date Filed 12/9/40

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.