

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3720**

FILED FEB 3 1949

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 14	
1. PLACE OF DEATH a. COUNTY Scott				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY New Madrid			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Libertown, Missouri		c. LENGTH OF STAY (In this place) 72 Days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Morehouse, Missouri.		72	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION McCommunity Delta Hospital				d. STREET ADDRESS (If rural, give location) (City) Morehouse, Mo.			
3. NAME OF DECEASED (Type or Print) a. (First) Ila b. (Middle) Bessie c. (Last) Sizemore			4. DATE OF DEATH (Month) (Day) (Year) Jan. 25 1949				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH 5-9-1889	
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months 8 Days 16		IF UNDER 48 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Berry Ferry Ky.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Luther Glass		13b. MOTHER'S MAIDEN NAME Lizzie Bailey		14. NAME OF HUSBAND OR WIFE - - - - -			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) No		16. SOCIAL SECURITY NO. - - -		17. INFORMANT'S SIGNATURE OR NAME Alley Sullivan		ADDRESS Morehouse, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION A				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) No substance Metastasis		DUPLICATE				5 3/4	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) No substance Soreness of foot				1 month	
		DUE TO (c) 					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION 2-5		19b. MAJOR FINDINGS OF OPERATION 2-10-49				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-1 , 1949, to 1-25 , 1949, that I last saw the deceased alive on 1-25 , 1949, and that death occurred at 11-20 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Sm Serna M.D.				23b. ADDRESS Morehouse Mo		23c. DATE SIGNED 1-26-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE Jan-27-49		24c. NAME OF CEMETERY OR CREMATORY Macdonia Cemetery		24d. LOCATION (City, town, or county) (State) Kuttawa Ky.	
DATE REC'D BY LOCAL REG. Jan. 31 1949		REGISTRAR'S SIGNATURE Mrs J. P. Henry		25. FUNERAL DIRECTOR'S SIGNATURE Reynolds Funeral Home		ADDRESS Libertown Mo	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No.

District File Number 249-12

Date Filed 2-1-41

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 _____

James M. Scott Student Embalmer No. 251
working under my personal supervision.

Signed James M. Scott
Student Embalmer

Signed James M. Scott
Licensed Embalmer No. 4350

P. O. Address East View, Md

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, fact should be so stated above.

James M. Scott