

FILED AUG 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28997

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 6117		Registrar's No. 96		
1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Diehlstadt (Rural)</b>		c. LENGTH OF STAY (in this place) <b>2 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Diehlstadt (Rural)</b>		d. STREET ADDRESS (If rural, give location) <b>Bertrand Route 1</b>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) "HOSPITAL OR INSTITUTION" <b>Bertrand Route 1</b>				d. STREET ADDRESS (If rural, give location) <b>Bertrand Route 1</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Donnie</b> b. (Middle) <b>Lee</b> c. (Last) <b>Hightower</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 8, 1949</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____		8. DATE OF BIRTH <b>Aug. 6, 1949</b>		
9. AGE (In years last birthday) _____		IF UNDER 1 YEAR Months _____		IF UNDER 24 HRS. Hours _____		IF UNDER 1 MIN. Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Diehlstadt, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Cecil Hightower</b>			13b. MOTHER'S MAIDEN NAME <b>Mable Thurkill</b>			14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Cecil Hightower, Route 1, Bertrand,</b> ADDRESS <b>Mo.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Premitture</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH          <b>776A</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					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) _____		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 <b>8-6, 1949</b> to <b>8-6, 1949</b> that I last saw the deceased alive on <b>8-6, 1949</b> and that death occurred at <b>7:45A</b> m., from the causes and on the date stated above.								
23a. SIGNATURE <b>Ella Lott</b> (Degree or title) <b>Midwife U</b>			23b. ADDRESS <b>Charleston, Mo. R 2 Box 175 A</b>			23c. DATE SIGNED <b>8-8-49</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Aug. 8, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Charleston, Mo.</b>		
DATE REC'D BY LOCAL REG <b>Aug 12-49</b>		REGISTRAR'S SIGNATURE <b>Mrs Ella Lott</b>		FUNERAL DIRECTOR'S SIGNATURE <b>F. J. Sparks</b> ADDRESS <b>Charleston, Mo.</b>				

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

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED - AUG 9 10  
District Health Office No. 2,  
District File Number 849-800  
Date Filed \_\_\_\_\_

**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.

Signed Frank Sparks

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3450

P. O. Address Rep. Grandaw

**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.