

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43382

State File No. _____

FILED JAN 7 1950

BIRTH NO. _____		REG. DIST. NO. <u>333</u>		PRIMARY REG. DIST. NO. <u>3074</u>		Registrar's No. <u>179</u>	
1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>Madison</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Sikeston</u>		c. LENGTH OF STAY (in this place) <u>13 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Parma, Mo</u>		d. STREET ADDRESS (If rural, give location) <u>4 mi North of Parma</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Delta Community Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>4 mi North of Parma</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u> b. (Middle) <u>M. CLAUD</u> c. (Last) <u>AYCOCK</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 16 1949</u>				
5. SEX <u>M.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 10 - 1876</u>	
9. AGE (In years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Clay County, Miss.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Clay County, Miss.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Frank Aycock</u>			13b. MOTHER'S MAIDEN NAME <u>Sally Thompson</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Aycock</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert Aycock Parma, Mo Mo</u>			
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) <u>Ch Myocarditis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hrs.</u>	
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 <u>12-1</u> , 19 <u>49</u> , to <u>12-16</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>12-16</u> , 19 <u>49</u> , and that death occurred at <u>2:00 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>D. G. Larns</u> (Degree or title)				23b. ADDRESS <u>Parma, Mo</u>		23c. DATE SIGNED <u>12-27-49</u>	
24a. DATE OF CREMATION REMOVAL (Specify)		24b. DATE <u>12/18/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Dexter</u>		24d. LOCATION (City, town, or county) (State) <u>Dexter Mo.</u>	
DATE REC'D BY LOCAL REG <u>Dec 29-49</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Waldens Funeral Service, Parma Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED DEC 31 11
District Health Office N
District File Number 124-15
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 Walter Marsh Watkins

Signed _____
Student Embalmer

Licensed Embalmer No. 4717

P. O. Address Dexter, Mo.

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.