

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43383**

FILED DEC 17 1949

BIRTH NO. _____ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. **166**

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Arkansas b. COUNTY Mississippi	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Dell	
c. LENGTH OF STAY (In this place) 90 days		d. STREET ADDRESS (If rural, give location) Route 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION 206 Trotter			

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) Elisa	c. (Last) Beatty	4. DATE OF DEATH (Month) (Day) (Year)
				11 18 49

5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 1/16/69	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 10	IF UNDER 1 YEAR Days 2	IF UNDER 24 HRS. Hours 	Min.
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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) Perry Co. Tenn.	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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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 Murphy Beatty	ADDRESS Tenn. Tenn.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		17-Nov-49
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension		10-15 yrs
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility		331X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Aug 15, 1949**, to **18-Nov, 1949**, that I last saw the deceased alive on **18-Nov, 1949**, and that death occurred at **4:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE H. B. Shryver	(Degree or title) M.D.	23b. ADDRESS Sikeston, Mo.	23c. DATE SIGNED 6-Dec-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/20/49	24c. NAME OF CEMETERY OR CREMATORY Matthews, Mo. Cemetery	24d. LOCATION (City, town, or county) (State) Matthews, Mo.
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DATE REC'D BY LOCAL REG. Dec 7-49	REGISTRAR'S SIGNATURE Mrs. Ella Hunter	25. FUNERAL DIRECTOR'S SIGNATURE Hunter	ADDRESS Albion Sikeston
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

5-2

RECEIVED DEC 1 1919
District Health Office
District File Number 1249-
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.

Student
Student Embalmer

Signed

John A. [Signature]

Licensed Embalmer No.

2941

P. O. Address

[Signature]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.