No. 300
10-48

FILED JUN 5 1950

THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 16595

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 13

1461

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

**1. PLACE OF DEATH**
a. COUNTY: HOWELL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): West Plains
c. LENGTH OF STAY (in this place): 9 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHRISTA HOGAN HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: HOWELL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WEST PLAINS
d. STREET ADDRESS (If rural, give location): 219 Summit

**3. NAME OF DECEASED** (Type or Print)
a. (First): JOHN
b. (Middle): WILLIAM
c. (Last): SEXTON

**4. DATE OF DEATH** (Month) (Day) (Year): MAY 20, 1950

**5. SEX**: MALE
**6. COLOR OR RACE**: WHITE
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): MARRIED
**8. DATE OF BIRTH**: DEC. 17, 1882
**9. AGE** (In years last birthday): 67 — If under 1 year: Months 5, Days 3 — If under 24 hrs.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): MINISTER
**10b. KIND OF BUSINESS OR INDUSTRY**: PRESBYTERIAN CHURCH
**11. BIRTHPLACE** (State or foreign country): GATESHEAD, ENGLAND
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A. (1946)

**13a. FATHER'S NAME**: STEPHEN SEXTON
**13b. MOTHER'S MAIDEN NAME**: KATHERINE PALMER
**14. NAME OF HUSBAND OR WIFE**: IRMA PERRY SEXTON

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No. (If yes, give war or dates of service): (CANADIAN ARMY W.W.I.)
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT'S SIGNATURE OR NAME ADDRESS**: MRS. IRMA SEXTON, W. PLAINS, MO.

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Diabetes Mellitus — 10 yrs.
DUE TO (c) Hypertension — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.* 2 days

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION**
**20. AUTOPSY?** YES ☐ NO ☐

**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 ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* 8-10, 1948, *to* 5-20, 1950, *that I last saw the deceased alive on* 5-20, 1950, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): C. Callison M.D.O
**23b. ADDRESS**: West Plains, Mo
**23c. DATE SIGNED**: 5/22/50

**24a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**24b. DATE**: MAY 23, 1950
**24c. NAME OF CEMETERY OR CREMATORY**: OAK LAWN CEM.
**24d. LOCATION** (City, town, or county) (State): WEST PLAINS, MO.

**DATE REC'D BY LOCAL REG.**: 5-24-50
**REGISTRAR'S SIGNATURE**: Beatrice Cook 379
**25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS**: Hal Hollingsworth, W. PLAINS, MO.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 5-29-50
District Health Officer No. 5,
District File Number 550 324
Date Filed 5-31-50

JUL 16 1952

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 Hal Thoroughgood

Licensed Embalmer No. 3408

P. O. Address West Plains, M

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

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