

FILED AUG 11 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24149**

*NO 31*

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **239** PRIMARY REG. DIST. NO. **5821** Registrar's No. **42**

1. PLACE OF DEATH a. COUNTY <b>NEW MADRID</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>SCOTT</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>RURAL</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SIKESTON 1002</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>U.S. HIGHWAY 61 - 1/2 mi S. MATTHEWS MO</b>		d. STREET ADDRESS (If rural, give location) <b>1</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>CARL</b> b. (Middle) <b>HARRISON</b> c. (Last) <b>DELPLANE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>7-13-50</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED 1</b>	8. DATE OF BIRTH <b>FEB 22 1916</b>
9. AGE (In years last birthday) <b>34</b>		10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIPE LINE CONST.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GAS LINE CONST</b>	11. BIRTHPLACE (State or foreign country) <b>SCOTT Co MO</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>R.D. DELPLANE</b>	
13b. MOTHER'S MAIDEN NAME <b>IDA MITCHAM</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs Lillie Delplane</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>499-07-4916</b>	
17. INFORMANT'S SIGNATURE OR NAME _____		ADDRESS _____	
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>Skull fracture - back</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>of head, fell out of</b> DUE TO (c) <b>pitch-up truck onto</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Wagons on highway</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>61 # 1/2 miles south of Sikeston</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway</b>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <b>New Madrid - 1572 MO</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>July 13 - 50 6:00 m.</b>	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Ed Hedgicott</b> (Degree or title) <b>Coroner</b>		23b. ADDRESS <b>New Madrid - Mo</b>	
23c. DATE SIGNED <b>7/13/50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>7-17-1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>	24d. LOCATION (City, town, or county) (State) <b>SIKESTON MO</b>
DATE REC'D BY LOCAL REG. <b>7-25-50</b>	REGISTRAR'S SIGNATURE <b>Helen Loui Jones</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Welsh Funeral Home - Sikeston Mo</b> ADDRESS _____	

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

FEB 26 1951

RECEIVED AUG 8 1950  
District Health Office No. 6,  
District File Number \_\_\_\_\_  
Date Filed \_\_\_\_\_

AUG 10 1950

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

*Raymond Crews*

Licensed Embalmer No.

*3467*

P. O. Address

*Sikeston 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.