

FILED OCT 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35886

BIRTH NO. 62704-50 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 150

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give township) Sikeston		c. CITY (If outside corporate limits, write RURAL and give township) Catron 0720	
c. LENGTH OF STAY (In this place) 15H 15M		d. STREET ADDRESS (If rural, give location) R. # 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Comm. Hospital			
3. NAME OF DECEASED a. (First) Paul		b. (Middle) Michael	
c. (Last) Gaines		4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1950	
5. SEX Male <input type="radio"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Sept. 27, 1950
9. AGE (In years last birthday) 15		10. MONTHS 11	11. DAYS 15
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) Sikeston, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Vergil M. Gaines		13b. MOTHER'S MAIDEN NAME Martha Mae Hicks	
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 Martha M. Gaines, Catron, Mo. R. # 1		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) Immaturity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Less than 6 months gestation DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 9-27, 1950, to 9-27, 1950, that I last saw the deceased alive on 9-27, 1950, and that death occurred at 10:45 P. M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Alden Sargent M.D.		23b. ADDRESS Sikeston, Mo.	
23c. DATE SIGNED 10-10-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Sep 28-50	
24c. NAME OF CEMETERY OR CREMATORY Matthews		24d. LOCATION (City, town, or county) (State) Matthews M-B	
DATE REC'D BY LOCAL REG. Oct 19-50		REGISTRAR'S SIGNATURE Mrs Ella Hunter	
25. FUNERAL DIRECTOR'S SIGNATURE (Licensed Embalmer's Statement on Reverse Side) Walker Funeral Service		Parma MO	

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

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RECEIVED OCT 23 1950
SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 1050-13

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 _____

was not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed  _____

Licensed Embalmer No. _____

P. O. Address _____

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.