

FILED NOV 3 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35887

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 156	
1. PLACE OF DEATH a. COUNTY Scott				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before a. STATE Missouri b. COUNTY Mississippi			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston		c. LENGTH OF STAY (in this place) 16 hrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Charleston (Rural) 0672			
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Community Hospital				d. STREET ADDRESS (If rural, give location) Route 3, Box 224			
3. NAME OF DECEASED (Type or Print) a. (First) Cresie			b. (Middle) _____		c. (Last) Maines		4. DATE OF DEATH (Month) (Day) (Year) Oct. 17, 1950
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /	8. DATE OF BIRTH Oct. 9, 1922		9. AGE (In years last birthday) 28	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 8 Hours _____
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) Arkadelphia, Arkansas /		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Winston Carter		13b. MOTHER'S MAIDEN NAME Willie Wright		14. NAME OF HUSBAND OR WIFE Willie Maines			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Willie Maines, R.3, Charleston, Missouri			
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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ Diabetic coma  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ Diabetes Mellitus  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.  26. 0X						INTERVAL BETWEEN ONSET AND DEATH  18 hrs.
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) (Minute) _____		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 10-16-1950, to 10-17, 1950, that I last saw the deceased alive on 10-17, 1950, and that death occurred at 4:30A m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) D. Urban M.D.				23b. ADDRESS Sikeston, Mo.		23c. DATE SIGNED 10/21/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE October 17, 1950	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		24d. LOCATION (City, town, or county) (State) Charleston, Missouri		
DATE REC'D BY LOCAL REG. Oct 25-50		REGISTRAR'S SIGNATURE Mrs. Ellen Hunter		25. FUNERAL DIRECTOR'S SIGNATURE A. J. Sparks		ADDRESS Charleston, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

100-7

RECEIVED OCT 30 1950  
J. SCOTT COUNTY HEALTH CENTER  
CO. FILE NO. 1050-144

**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 Frank J. Sparks.....

Licensed Embalmer No. 3455.....

P. O. Address Cap. Buchanan.....

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.

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