

DEC 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43278

State File No.

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 183

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY OR TOWN <u>Sikeston, Missouri</u>	c. LENGTH OF STAY (in this place) <u>10 days</u>	c. CITY OR TOWN <u>Sikeston</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Delta Community Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>516 NEW ST.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u> b. (Middle) <u>S</u> c. (Last) <u>BRITTON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>DECEMBER 10, 1950</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>MARCH 11, 1864</u>	9. AGE (in years last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days	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) <u>Day goods Merchant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>LADIES READY WEAR</u>	11. BIRTHPLACE (State or foreign country) <u>EFFINGHAM CO ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>JOHN BRITTON</u>	13b. MOTHER'S MAIDEN NAME <u>RUTH BEANIE</u>	14. NAME OF HUSBAND OR WIFE <u>NELLIE MAE BRITTON (DEC)</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS EARL ALLEN</u> ADDRESS <u>Sikeston Mo</u>
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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 <u>10 days</u> <u>89030</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fracture of Left Femur</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>infirmitas of age -</u> DUE TO (c) <u>-</u>		
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 checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at home</u>	21c. (CITY/TOWN OR TOWNSHIP) (COUNTY) (STATE) <u>Sikeston Scott Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Dec 1 1950 10:00 AM</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Sitting into wheel chair.</u>
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22. I hereby certify that I attended the deceased from 1-Dec, 1950, to 10-Dec, 1950, that I last saw the deceased alive on 10-Dec, 1950, and that death occurred at 10:00 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>H. B. Proffert M.D.</u>	23b. ADDRESS <u>Sikeston, Mo</u>	23c. DATE SIGNED <u>10-Dec-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>Dec. 12, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Thistlewood</u>	24d. LOCATION (City, town, or county) (State) <u>Mounds Pulaski Co., Ill.</u>
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DATE REC'D BY LOCAL REG. <u>Dec. 13, 50</u>	REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter W. Lester</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C. Marshall</u> ADDRESS <u>(3073) Cairo, Ill</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

RECEIVED DEC 18 195

SCOTT COUNTY HEALTH CENT

CO. FILE NO. 1250 - /

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 _____

by me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Lester C. Marchildon*

Licensed Embalmer No. 8332 Ills

P. O. Address Cairo, Illinois

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.