

FILED MAR 16 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11240

State File No.

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3024 Registrar's No. 51

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>STODDARD</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SIKESTON, MISSOURI</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL LIBERTY TWP</u> <u>1030</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MO. DELTA COMMUNITY HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>2 MILES NORTH OF BERNIE, MISSOURI</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>REBECCA</u>	b. (Middle) <u>JEWEL</u>	c. (Last) <u>PARRIS</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>2</u> <u>27</u> <u>51</u>

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) NEVER MARRIED <u>✓</u>	8. DATE OF BIRTH <u>8/17/50</u>	9. AGE (In years last birthday) <u>6</u> Months <u>10</u> Days	IF UNDER 1 YEAR <u>10</u> Hours <u></u> Min.
----------------------	-------------------------------	--	---------------------------------	--	--

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) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	-----------------------------------	---	--

13a. FATHER'S NAME <u>WALTER PARRIS</u>	13b. MOTHER'S MAIDEN NAME <u> VIRGINIA NIMMO</u>	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>WALTER PARRIS</u> ADDRESS <u>BERNIE, Mo</u>
---	--	--

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		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia, Bronchial</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <u>Aspirated pneumonia</u>	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-27, 1951, to 2-27, 1951, that I last saw the deceased alive on 2-27, 1951, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Walter Parris</u>	23b. ADDRESS <u>Liberton Mo</u>	23c. DATE SIGNED <u>2-27-51</u>
---	---------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>2/27/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>BERNIE, CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>BERNIE, MISSOURI</u>
---	--------------------------	--	---

DATE REC'D BY LOCAL REG. <u>Mar 9 '51</u>	REGISTRAR'S SIGNATURE <u>Mr. Ella Hunter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Becker</u> ADDRESS <u>Berrie</u>
---	--	--

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

RECEIVED MAR 12 1951

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 351-66

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 _____

Body Not Embalmed

Student ~~Embalmer~~ No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *[Signature]*

~~_____~~ *General Director*

P. O. Address *Berrie*

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.

[Faint handwritten marks]