

FILED APR 27 1951

STANDARD CERTIFICATE OF DEATH

13769

State File No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. 1002 | | Registrar's No. 3432 | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS | | c. LENGTH OF STAY (in this place) _____ | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SIKESTON 1003 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS MATERNITY HOSPITAL | | | | d. STREET ADDRESS (If rural, give location) 715 NEW STREET 1 | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) LUCY | | b. (Middle) ANN | | c. (Last) BEAN | | 4. DATE OF DEATH (Month) (Day) (Year) APRIL 9 1951 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2 | 8. DATE OF BIRTH OCTOBER 10 1901 49 | | 9. AGE (In years last birthday) _____ | IF UNDER 1 YEAR Months _____ | IF UNDER 1 HOUR Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) WHITE COUNTY, ILLINOIS | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME JIM HEWITT | | | 13b. MOTHER'S MAIDEN NAME MALINDA STOKES | | 14. NAME OF HUSBAND OR WIFE CLARENCE BEAN (DECEASED) | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 2 | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME Harold Bean Sikeston | | ADDRESS Mo | |
| 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 | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Peritonitis | | | | | | | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | DUE TO (b) Rupture of parametrial abscess | | | |
| | | | | DUE TO (c) _____ | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | Squamous Cell Carcinoma of Uterus | | | |
| 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? 1718 126X | | | |
| 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 (Degree or title) Carl W. Woolsey M.D. | | | | 23b. ADDRESS Barnes Maternity Hosp | | 23c. DATE SIGNED 4-9-51 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 4-10-51 | | 24c. NAME OF CEMETERY OR CREMATORY Sikeston | | 24d. LOCATION (City, town, or county) (State) Mo | |
| DATE RECD BY LOCAL REG. APR 12 1951 | | REGISTRAR'S SIGNATURE J. B. Lassiter | | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Rowland Mortuary Service St. Louis 10, Mo. | | | |

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

2819

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 Ronald O. Johnson

Licensed Embalmer No. 3917

P. O. Address St. Louis 10 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.