

FILED APR 21 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15245

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 66

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

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) OR TOWN Sikeston		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kewanee	
c. LENGTH OF STAY (In this place) 6 days		d. STREET ADDRESS (If rural, give location) 072-0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Delta Comm. Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Frank c. (Last) Cagle			4. DATE OF DEATH (Month) (Day) (Year) Feb. 15, 1951		
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5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH March 23, 1889		9. AGE (In years last birthday) 61		IF UNDER 1 YEAR Months Days Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Jim Cagle		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Lela Cagle	
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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) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME James Cagle Kewanee, Mo.		ADDRESS	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cirrhosis of liver 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. _____				INTERVAL BETWEEN ONSET AND DEATH 1 yr	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 5810				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **1-15, 1951**, to **2-15, 1951**, that I last saw the deceased alive on **2-15, 1951**, and that death occurred at **11:59 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE E. O. Urban		(Degree or title) M.D.		23b. ADDRESS Sikeston		23c. DATE SIGNED 3-31-51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 17, 1951		24c. NAME OF CEMETERY OR CREMATORY Mounds		24d. LOCATION (City, town, or county) (State) Near New Madrid, Missouri	
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DATE REC'D BY LOCAL REG. 4-11-51		REGISTRAR'S SIGNATURE Mrs. Ella Hunter		4295		25. FUNERAL DIRECTOR'S SIGNATURE Richard's Mort Co New Madrid		ADDRESS	
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RECEIVED APR 16 1951

SCOTT COUNTY HEALTH CENT

CO. FILE NO. 451-8

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

L. B. Hedgesmith

Licensed Embalmer No. 3803

P. O. Address New Madrid, 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.