

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **30873**

FILED OCT 1 1951

BIRTH NO. _____ REG. DIST. NO. 218 PRIMARY REG. DIST. NO. 5790 Registrar's No. 57

0670

1. PLACE OF DEATH a. COUNTY Mississippi		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Missouri b. COUNTY Mississippi	
b. CITY OR TOWN Wolf Island	c. LENGTH OF STAY (In this place) 49 YRS.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wolf Island 0670	
d. FULL NAME OF HOSPITAL OR INSTITUTION Box 13		d. STREET ADDRESS (If rural, give location) Box 13 0	

3. NAME OF DECEASED (Type or Print) Earsie Cotton			4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1951	
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 2, 1900	9. AGE (In years last birthday) 51
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) Tenn. /	
12. CITIZEN OF WHAT COUNTRY? USA				

13a. FATHER'S NAME Charles Fowlkes	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Jim Cotton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) NO	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Jim Cotton, Box 13, Wolf Island, 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, asthma, 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) Metastatic Carcinoma		7 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of cervix DUE TO (c) _____		8 mo.
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 171X	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) _____	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 June, 1951, to Sept, 1951, that I last saw the deceased alive on Sept 18, 1951, and that death occurred at 3:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE D. P. Fulton D.O.	(Degree or title)	23b. ADDRESS Wyatt Mo	23c. DATE SIGNED 9/22/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 23, 1951	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	24d. LOCATION (City, town, or county) (State) Charleston, Missouri

DATE REC'D BY LOCAL REG. 9-26-51	REGISTRAR'S SIGNATURE Letaude L. Harper	197	25. FUNERAL DIRECTOR'S SIGNATURE F. D. Sparks	ADDRESS Charleston, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 28 REC'D

RECEIVED

Miss. Co. Health Dep

County File No. _____

Date Filed SEP 28 1951

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Frank J. Sparks

Signed.....
Student Embalmer

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau

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.