

AUG 29 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30485

State File No.

169

BIRTH NO. _____		REG. DIST. NO. <u>333</u>		PRIMARY REG. DIST. NO. <u>0074</u>		Registrar's No. _____	
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>New Madrid</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>		c. LENGTH OF STAY (In this place) <u>11 Hour</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>Route 3</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Rebecca</u> b. (Middle) <u>Susie</u> c. (Last) <u>Huggins</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 9 1952</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-28-1887</u>		9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Wid Hutcheson</u>		13b. MOTHER'S MAIDEN NAME <u>Nervy Cook</u>		14. NAME OF HUSBAND OR WIFE <u>Wid Huggins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Mary Manning, Sikeston, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Rt. Lobar Pneumonia</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Cardiovascular Disease</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u> </u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>SIKESTON SCOTT MO</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug 28 52</u>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>RECURRENCE OF PREVIOUS ILLNESS</u>					
22. I hereby certify that I attended the deceased from <u>July 28, 1952</u> to <u>Aug 9, 1952</u> ; that I last saw the deceased alive on <u>Aug 8, 1952</u> , and that death occurred at <u>8:25 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Audra B. Smith</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>801 MOORE SIKESTON</u>		23c. DATE SIGNED <u>9 Aug 52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		24b. DATE <u>8/11/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>plumerville</u>		24d. LOCATION (City, town, or county) (State) <u>Russellville Ark</u>		
DATE REC'D BY LOCAL REG. <u>8-22-52</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>		FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Jones</u>		ADDRESS <u>Sikeston Mo</u>	

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

RECEIVED AUG 25 1952
SCOTT COUNTY HEALTH CENTER
CO. FILE NO. 852-252

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.....
Student Embalmer

Signed John Allerton

Licensed Embalmer No. 2941

P. O. Address Spokane

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.