

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30487

State File No. _____

FILED AUG 22 1952

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 163

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

| | | | | | |
|--|--|-----------------------------------|---|--|-------|
| 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>Scott</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston, Mo</u> | | c. LENGTH OF STAY (In this place) | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston, Mo</u> | | 10-23 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>706 Troy St Sikeston, Mo</u> | | | d. STREET ADDRESS (If rural, give location) <u>706 Troy St Sikeston, Mo</u> | | |

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|-------------------------------------|------------------------|----------------------|-------------------------|---------------------------------------|-------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>J.A.</u> | b. (Middle) <u>O</u> | c. (Last) <u>Learue</u> | 4. DATE OF DEATH (Month) (Day) (Year) | <u>8</u> <u>1</u> <u>1952</u> |
|-------------------------------------|------------------------|----------------------|-------------------------|---------------------------------------|-------------------------------|

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|-----------------|---------------------------|---|---------------------------------|---|---------------------------------|-------------------------------------|
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u> | 8. DATE OF BIRTH <u>3/28/81</u> | 9. AGE (In years last birthday) <u>71</u> | IF UNDER 1 YEAR Months <u>4</u> | IF UNDER 6 mos. Hours <u>4</u> Min. |
|-----------------|---------------------------|---|---------------------------------|---|---------------------------------|-------------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton & Corn</u> | 11. BIRTHPLACE (State or foreign country) <u>Tenn</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|--|---|--|

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|---------------------------------------|--|---|
| 13a. FATHER'S NAME <u>John Learue</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Annie Learue</u> |
|---------------------------------------|--|---|

| | | | |
|--|-------------------------------------|---|--------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Annie Learue</u> | ADDRESS <u>706 Troy Sikeston, Mo</u> |
|--|-------------------------------------|---|--------------------------------------|

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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, asphyxia, etc. It means the disease, injury, or complication which caused death. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac decompensation</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> | | |
| | DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|------------------------|--|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>4500</u> | 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) |
|--|--|---|

| | | |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 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 May, 1952, to 8-1, 1952, that I last saw the deceased alive on 7/31, 1952, and that death occurred at 4:55 p.m., from the causes and on the date stated above.

| | | |
|---|------------------------------|---------------------------------|
| 23a. SIGNATURE <u>E. D. Urban, M.D.</u> (Degree or title) | 23b. ADDRESS <u>Sikeston</u> | 23c. DATE SIGNED <u>8-11-52</u> |
|---|------------------------------|---------------------------------|

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|---|-------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>8/2/52</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Matthews Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Matthews Mo</u> |
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| | | | |
|---|---|---|------------------------------|
| DATE REC'D BY LOCAL REG. <u>8-12-52</u> | REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u> | GENERAL DIRECTOR'S SIGNATURE <u>Thurgood Marshall</u> | ADDRESS <u>St. Louis, Mo</u> |
|---|---|---|------------------------------|

AUG 18 1952

RECEIVED

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 852-248

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 John Allerton

Signed.....
Student Embalmer

Licensed Embalmer No. 7941

P. O. Address Scott County, 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.