No. 300
10.48

FILED MAR 13 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8434

BIRTH NO. 88348 REG. DIST. NO. 33V PRIMARY REG. DIST. NO. 4484 Registrar's No. 76

1. PLACE OF DEATH
a. COUNTY: Scott
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Commerce
c. LENGTH OF STAY (In this place): 1 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at W. G. Roach home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Scott
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Commerce 1000
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) EVELYN b. (Middle) DARLENE c. (Last) MERTZ

4. DATE OF DEATH: (Month) MAR (Day) 10 (Year) 1953

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Dec 2, 1952
9. AGE (In years last birthday): 0
IF UNDER 1 YEAR: Months 3 Days 8
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): St Louis, Mo
12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME: JOHN MERTZ
13b. MOTHER'S MAIDEN NAME: ELIZABETH HOLDER
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: John Mertz ADDRESS: Commerce 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) possibly virus
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

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 21, 1953, *to* Dec 27, 1953, *that I last saw the deceased alive on* Dec 23, 1953 *and that death occurred at* 7 *m., from the causes and on the date stated above.*

23a. SIGNATURE: N. G. Lee (Degree or title) M.D.
23b. ADDRESS: Sikeston Mo
23c. DATE SIGNED: 3/10/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-11-53
24c. NAME OF CEMETERY OR CREMATORY: Lightner
24d. LOCATION (City, town, or county) (State): Sikeston Mo

DATE REC'D BY LOCAL REG.: Mar 11 53
REGISTRAR'S SIGNATURE: Mrs Addie Harris
25. FUNERAL DIRECTOR'S SIGNATURE: Bagby Hoff Funeral Home ADDRESS: Sikeston Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 3-12-53
SCOTT COUNTY HEALTH CENTER
CO. FILE NO. 553-66

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 Oliver C. Smith

Licensed Embalmer No. 4470

P. O. Address Illmo, 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.