

FILED MAY 1 1953

STANDARD CERTIFICATE OF DEATH

16751  
 State File No.

|   |                               |   |  |   |   |   |   |
|---|-------------------------------|---|--|---|---|---|---|
| BIRTH NO.   |                               | REG. DIST. NO.  |  | PRIMARY REG. DIST. NO.  |   | Registrar's No. 68  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>SCOTT</u>   |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Mo</u><br>b. COUNTY <u>SCOTT</u> |   |   |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>SIKESTON</u>   |                               | c. LENGTH OF STAY (in this place)<br><u>16 yrs</u>  |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>SIKESTON 1003</u>  |   |   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>714 TROY</u>  |                               |   |  | d. STREET ADDRESS (If rural, give location)<br><u>714 TROY</u>  |   |   |   |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>JAMES</u>  |                               |   | b. (Middle) <u>TOMAS</u>                                   |   | c. (Last) <u>MCCAWLEY</u>   |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>4-19-1953</u> |
| 5. SEX <u>MALE</u>  | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>MARRIED</u>  |  | 8. DATE OF BIRTH<br><u>12-22-1886</u>   | 9. AGE (in years last birthday)<br><u>66</u>                        | 10. UNDER 1 YEAR<br>Months  | 11. UNDER 12 Mths.<br>Days                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RET. FARMER</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>OBION TENN 1</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13a. FATHER'S NAME<br><u>WM. CHRISTIANER</u>  |                               |   | 13b. MOTHER'S MAIDEN NAME<br><u>MARY JANE GRAY</u>         |   | 14. NAME OF HUSBAND OR WIFE<br><u>AUDREY CAPPS McCAWLEY</u>         |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |                               | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Mrs Audrey McCawley Sikeston Mo</u>   |   |   |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral accident with paralysis</u>                                 |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 years</u>        |
|   |                               | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertension</u> |  |   |   |   |   |
|   |                               | DUE TO (c)  |  |   |   |   |   |
|   |                               | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                     |  |   |   |   |   |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION<br><u>331X</u>   |  |   |   | 20. AUTOPSY?<br>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 _____, 19____, to <u>April 18, 1953</u> , that I last saw the deceased alive on <u>April 18, 1953</u> , and that death occurred at <u>11 A</u> m., from the causes and on the date stated above. |                               |   |  |   |   |   |   |
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title)   |                               |   |  | 23b. ADDRESS<br><u>Sikeston, Missouri</u>   |   | 23c. DATE SIGNED<br><u>4-25-53</u>  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                               | 24b. DATE<br><u>4-22-53</u>   | 24c. NAME OF CEMETERY OR CREMATORY<br><u>MEMORIAL PARK</u> |   | 24d. LOCATION (City, town, or county) (State)<br><u>SIKESTON MO</u> |   |   |
| DATE REC'D BY LOCAL REG.<br><u>4-25-53</u>  |                               | REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Welsh Funeral Home Sikeston Mo</u>   |   |   |   |

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

RECEIVED APR 27 1953  
SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 453-102

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Leicester, Me.

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.