

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34738

FILED OCT 2 - 1953

State File No. \_\_\_\_\_

BIRTH NO. 33849 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 146

|  |  |   |  |
|--|--|---|--|
| 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>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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Madrid</u>  |  |
| c. LENGTH OF STAY (in this place) <u>Life</u>  |  | d. STREET ADDRESS (If rural, give location) <u>336 Lewis Street</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hosp</u>                      |  |   |  |

|                                     |                         |                          |                             |   |
|-------------------------------------|-------------------------|--------------------------|-----------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Teddy</u> | b. (Middle) <u>Odell</u> | c. (Last) <u>Harralston</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>9-9-1953</u> |
|-------------------------------------|-------------------------|--------------------------|-----------------------------|---|

|                    |                               |  |                                   |  |                                 |                      |                       |                        |
|--------------------|-------------------------------|--|-----------------------------------|--|---------------------------------|----------------------|-----------------------|------------------------|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Baby</u> | 8. DATE OF BIRTH <u>5-16-1953</u> | 9. AGE (in years last birthday) <u>3</u> | IF UNDER 1 YEAR Months <u>3</u> | IF UNDER 1 YEAR Days | IF UNDER 1 Hrs. Hours | IF UNDER 1 Mins. Mins. |
|--------------------|-------------------------------|--|-----------------------------------|--|---------------------------------|----------------------|-----------------------|------------------------|

|   |   |  |  |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baby</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Sikeston, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|---|--|--|

|  |   |  |
|--|---|--|
| 13a. FATHER'S NAME <u>Odell Harralston</u> | 13b. MOTHER'S MAIDEN NAME <u>Marie Tanner</u> | 14. NAME OF HUSBAND OR WIFE <u>---</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>---</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Odell Harralston</u> | ADDRESS <u>New Madrid, 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   |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocardial Infarction</u>   |  |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>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 <u>2040</u> | 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) (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 9-8-1953 to 9-9-1953, that I last saw the deceased alive on 9-9-1953 and that death occurred at 2:00 P.M. from the causes and on the date stated above.

|  |                                 |                                 |
|--|---------------------------------|---------------------------------|
| 23a. SIGNATURE <u>G. J. Winters M.D.</u> (Degree or title) | 23b. ADDRESS <u>Director No</u> | 23c. DATE SIGNED <u>9-15-53</u> |
|--|---------------------------------|---------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>9/13/53</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Mounts</u> | 24d. LOCATION (City, town, or county) (State) <u>Near New Madrid Mo</u> |
|---|--------------------------|--|---|

|   |   |   |                               |
|---|---|---|-------------------------------|
| DATE REC'D BY LOCAL REG. <u>9-21-53</u> | REGISTRAR'S SIGNATURE <u>Mrs. Edna Hunter</u> 429 | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. S. H. Smith</u> | ADDRESS <u>New Madrid, Mo</u> |
|---|---|---|-------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED SEP 28 1953  
SCOTT COUNTY HEALTH CENTER  
CO. FILE NO. 453-217

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 *Leo H. Hedges*

Licensed Embalmer No. 3803

P. O. Address *New Madrid*

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.