

STANDARD CERTIFICATE OF DEATH

34759

State File No.

No. 300
10.48

FILED **SEP 18 1953**

BIRTH NO. _____		REG. DIST. NO. 331		PRIMARY REG. DIST. NO. 4486		Registrar's No. 80	
1. PLACE OF DEATH a. COUNTY SCOTT				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY SCOTT			
b. CITY OR TOWN BENTON		c. LENGTH OF STAY (in this place) 11 yrs		c. CITY OR TOWN BENTON		7000 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) JAMES			b. (Middle) AARON			c. (Last) REVELLE	
4. DATE OF DEATH 8-20-1953		5. SEX M		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH 11-7-1867		9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER			10b. KIND OF BUSINESS OR INDUSTRY FARMING			11. BIRTHPLACE (City and State or Foreign Country) FREDERICKTOWN MO	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME ALBERT		13b. MOTHER'S MAIDEN NAME SALLIE		14. NAME OF HUSBAND OR WIFE KIZZIE AGNES REVELLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Kizzie Agnes Lester Revelle - Minnie ADDRESS _____			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA DESCENDING Colon ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1.53X					
22. I hereby certify that I attended the deceased from 8/15 , 19 53 , to 8/19/53 , 19 53 , that I last saw the deceased alive on 8/19/53 , 19 53 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE McMinn, J. D.O. (Degree or title)				23b. ADDRESS Sikeston		23c. DATE SIGNED 9/14/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 8-22-1953		24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK		24d. LOCATION (City, town, or county) (State) SIKESTON MO	
DATE REC'D BY LOCAL REG. Sept-16-53		REGISTRAR'S SIGNATURE Mrs. Addie Harris		25. FUNERAL DIRECTOR'S SIGNATURE Wesley F. ... Home Sikeston Mo ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 9-17-53
SCOTT COUNTY HEALTH CENTER
CO. FILE NO. 953-205

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 Linton 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.