

300
48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 23 1953
67922

State File No. 37990
Registrar's No. 162

BIRTH NO. REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Scott	
b. CITY OR TOWN Sikeston	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN Sikeston	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Community Hosp.		d. STREET ADDRESS 520 New	

3. NAME OF DECEASED (Type or Print) Susan Marie Marie	a. (First)	b. (Middle)	c. (Last) Hahs	4. DATE OF DEATH 10-14-1953
---	------------	-------------	----------------	-----------------------------

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-8-1953	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 15 MIN. Mins.
---------------	------------------------	--	---------------------------	-----------------------------------	------------------------	------------------------	------------------------

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

13a. FATHER'S NAME William Hahs	13b. MOTHER'S MAIDEN NAME Mary Anne Lankford	14. NAME OF HUSBAND OR WIFE
---------------------------------	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mary Anne Lankford, Sikeston, Mo. ADDRESS Mary Anne Lankford, Sikeston, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Obstruction, intestinal & his.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>congenital rotational duodenal</u> DUE TO (c) <u>secondary volvulus of jejunum & ileum</u>		

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) m.	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 10-12, 1953, to 10-14, 1953, that I last saw the deceased alive on 10-14, 1953, and that death occurred at 4:00A. m., from the causes and on the date stated above.

23a. SIGNATURE G. J. Wacker MD (Degree or title)	23b. ADDRESS Sikeston Mo.	23c. DATE SIGNED 10-15-53
--	---------------------------	---------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 10-15-53	24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	24d. LOCATION (City, town, or county) STATE Sikeston Mo
--	--------------------	--	---

DATE REC'D BY LOCAL REG. 10-16-53	REGISTRAR'S SIGNATURE Mrs. E. A. Hunter 439	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Welch Funeral Home - Sikeston Mo
-----------------------------------	---	---

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

RECEIVED OCT 19 1953
SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 1053-237

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.....

Student Embalmer

Signed.....

Raymond Grews

Licensed Embalmer No. 3467

P. O. Address Sikeston

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.