

**THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

6/15 State File No. **3667**
 1981 *Revised*
 Registrar's No. **7**

No. 300
10.48

BIRTH NO. FILED FEB 5 1954 REG. DIST. NO. **332** PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Scott 1009		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Scott	
b. CITY OR TOWN RURAL		c. CITY OR TOWN Rural Sikeston	
c. LENGTH OF STAY (In this place) 3 wks		d. STREET ADDRESS (If rural, give location) R 4 1000	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rural Sikeston R 4			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) LENNIE	b. (Middle) LEE	c. (Last) ANDRESS	1 - 22 - 54		
5. SEX 2 MALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) C	8. DATE OF BIRTH Jan - 2 - 1954	9. AGE (In years last birthday) -	IF UNDER 1 YEAR: Months - Days 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ✓		10b. KIND OF BUSINESS OR INDUSTRY ✓		11. BIRTHPLACE (State or foreign country) RURAL - SIKESTON	
12. CITIZEN OF WHAT COUNTRY? U.S.A					

13a. FATHER'S NAME O. B. Andress	13b. MOTHER'S MAIDEN NAME Hattie B. Patterson	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME D. B. Andress ADDRESS 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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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?
-------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from no doctor in attendance, 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at 10:30 pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thelma C. Buckthorp, M.D. Health Officer	23b. ADDRESS Benton, Mo	23c. DATE SIGNED 1-25-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/23/54	24c. NAME OF CEMETERY OR CREMATORY Carpenter
DATE REC'D BY LOCAL REG. 1-25-54		24d. LOCATION (City, town, or county) (State) Sikeston Mo
REGISTRAR'S SIGNATURE Mr. Ollie Tucker		25. FUNERAL DIRECTOR'S SIGNATURE None O.B. Andress

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

RECEIVED FEB 1 1954
SCOTT COUNTY HEALTH CENTER
CO. FILE NO. 254-24

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.