

No. 300
10. 48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21751

State File No. _____

FILED JUL 12 1954

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 87

1003
0

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

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>		c. CITY OR TOWN <u>Sikeston</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>4 Days</u>		e. STREET ADDRESS (If rural, give location) <u>728 Smith Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Mo. Delta Community Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Cora</u>	b. (Middle) <u>Lee</u>	c. (Last) <u>Beaird</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>6 25 1954</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-18-1877</u>	9. AGE (In years last birthday) <u>77</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>—</u>
-----------------------------------	--	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Roy Beaird, Sikeston, Mo.</u>	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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Neuroaplegia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 <u>352 X</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) _____	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 6-19, 1954 to 6/25, 1954, that I last saw the deceased alive on 6-25, 1954, and that death occurred at 3:07 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Thomson C. Dr. Cleve</u>	23b. ADDRESS <u>Sikeston Mo</u>	23c. DATE SIGNED <u>6/28/54</u>
--	---------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>6-27-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>DOGWOOD</u>	24d. LOCATION (City, town, or county) (State) <u>Miss. Co. Mo</u>
---	--------------------------	---	---

DATE REC'D BY LOCAL REG. <u>7-1-54</u>	REGISTRAR'S SIGNATURE <u>429 Mrs. Cleve Hunter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Welsh Funeral Home - Sikeston Mo</u>	ADDRESS _____
--	--	--	---------------

DATE RECEIVED

JUL 6 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No.

754-131

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.....
Signature of Student Embalmer

Signed..... *Raymond Crews*

Licensed Embalmer No. *346*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.