

FILED AUG 6 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

25938

BIRTH NO. 49970-54 REC. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 107

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>Stoddard</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>		c. LENGTH OF STAY (In this place) <u>1 Day</u>		c. CITY OR TOWN <u>Bell City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>Route 1</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Vonda</u>			b. (Middle) <u>Jean</u>		c. (Last) <u>Hessling</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7 21 1954</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>7-20-1954</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>0</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>0</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Sikeston, Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ralph E. Hessling</u>			13b. MOTHER'S MAIDEN NAME <u>Freddie Pearl Lucy</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>0</u>			16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Freddie Hessling, Bell City, Mo.</u>				
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) <u>Meningeal Head</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>at death</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>7531</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <u>20 July 1954</u> , to <u>21 July, 1954</u> , that I last saw the deceased alive on <u>21 July, 1954</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>H.B. Throgmorton M.D.</u>				23b. ADDRESS <u>Sikeston Mo</u>			23c. DATE SIGNED <u>22 July 54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-22-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Gravel Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Bloomfield Stoddard Mo.</u>			
DATE REC'D BY LOCAL REG. <u>7-28-54</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter 429</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Chiles Und. Co. Bloomfield, Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

DATE RECEIVED AUG 2 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No. 854-159

STATEMENT BY LICENSED EMBALMER

No Embalming

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.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.