

FILED AUG 13 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25948

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 112

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 (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston		c. CITY OR TOWN Sikeston	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 Day		e. STREET ADDRESS (If rural, give location) Route 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mo. Delta Community Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Annie b. (Middle) Lee c. (Last) Williams			4. DATE OF DEATH (Month) 8 (Day) 1 (Year) 1954
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 7-23-1954
9. AGE (In years last birthday) -	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby	11. BIRTHPLACE (City and State or Foreign Country) Sikeston, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Will Williams	13b. MOTHER'S MAIDEN NAME Sadie Brooks	14. NAME OF HUSBAND OR WIFE 0	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes-no, or unknown) 0	16. SOCIAL SECURITY NO. 0	17. INFORMANT'S SIGNATURE OR NAME Mrs. Sadie Williams, Sikeston, Mo. 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) Tetanus Neonatorum INTERVAL BETWEEN ONSET AND DEATH 2 days ANTECEDENT CAUSES DUE TO (b) Non-sterile Delivery DUE TO (c) 061X II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION Tracheotomy	19b. MAJOR FINDINGS OF OPERATION Normal structures - laryngeal spasm		20. AUTOPSY? YES <input checked="" 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)	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 7/31, 1954 to 8/1, 1954 , that I last saw the deceased alive on 8/1E, 1954 , and that death occurred at 4:50 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Harold Lisicki, M.D. Morehouse, Mo.		23b. ADDRESS	23c. DATE SIGNED 8/3/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-3-54	24c. NAME OF CEMETERY OR CREMATORY Carpenters	24d. LOCATION (City, town, or county) (State) N.W. Sikeston, Mo.
DATE REC'D BY LOCAL REG. 8-4-54	REGISTRAR'S SIGNATURE Max Ellerhente	25. FUNERAL DIRECTOR'S SIGNATURE Fred Smith ADDRESS 1212 Maul Sikeston	

429-0 (Licensed Embalmer's Statement on Reverse Side)

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

AUG 9

DATE RECEIVED

SCOTT CO. HEALTH DEPT.

CO. FILE No. 954-159

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 *Not Embalmed*

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.