

FILED AUG 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29503**

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 1003	
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. LENGTH OF STAY (In this place) 7 Hours		c. CITY OR TOWN Sikeston		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Community Hospital				e. STREET ADDRESS (If rural, give location) 419 Prosperity St. 1003			
3. NAME OF DECEASED (Type or Print) a. (First) Mollie b. (Middle) - c. (Last) Cutrell			4. DATE OF DEATH (Month) (Day) (Year) 8 7 1954				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 2-27-1873	
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) Shawneetown, Illinois /	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Calvin Harris			13b. MOTHER'S MAIDEN NAME Blackburn		14. NAME OF HUSBAND OR WIFE James S. Cutrell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Paul Higgins, 319 Kendall, 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 9 hrs. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, generalized 20 yrs. 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) 331X			
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 8-6 , 19 54 , to 8-7 , 19 54 , that I last saw the deceased alive on 8-7 , 19 54 , and that death occurred at 6:30 A. m. , from the causes and on the date stated above.							
23a. SIGNATURE D. S. Blackburn M.D. (Degree or title)				23b. ADDRESS Sikeston, Mo.		23c. DATE SIGNED 8-10-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 8-8-54		24c. NAME OF CEMETERY OR CREMATORY City		24d. LOCATION (City, town, or county) (State) Sikeston Mo	
DATE REC'D BY LOCAL REG. Aug 11 1954		REGISTRAR'S SIGNATURE Mrs. Ella Hunter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Welch Funeral Home - Sikeston Mo.			

429-0

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10.48

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DATE RECEIVED AUG 16 1954
SCOTT CO. HEALTH DEPT.
CO. FILE No. 852-123

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. 3467

P. O. Address Leicester, W.

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.