

FILED OCT 1 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32773

State File No. ....

BIRTH NO. .... REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 138

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>	
b. CITY OR TOWN <b>Sikeston</b>	c. LENGTH OF STAY (in this place) <b>30 yrs.</b>	c. CITY OR TOWN <b>Sikeston</b>	d. In Residence within limits of a city or incorporated town? <b>Yes</b> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Delta Community Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>408 Ruth St.</b> <span style="float: right;">1003</span>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>William</b>	b. (Middle) <b>Wesley</b>	c. (Last) <b>Lankford</b>	<b>9</b>	<b>10</b>	<b>1954</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>10-16-1885</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ginner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cotton Gin</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Henning, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>W.J. Lankford</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Ann Adams</b>	14. NAME OF HUSBAND OR WIFE <b>Katherine Wellons</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>494-07-0253</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. W. W. Lankford, Sikeston, Mo.</b>	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypostatic Pneumonia</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Myocardial failure &amp; Renal failure</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular disease &amp; Hypertension</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>&amp; Nephrosclerosis + Labyrinthitis</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>
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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) (Min.)	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 8-1, 1954, to 9-10, 1954, that I last saw the deceased alive on 9-10, 1954, and that death occurred at 11:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Alden B. Sargent M.D.</b>	23b. ADDRESS <b>Sikeston, Mo.</b>	23c. DATE SIGNED <b>9-12-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>9-12-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>GARDEN OF MEMORIES</b>	24d. LOCATION (City, town, or county) (State) <b>SIKESTON MO</b>
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DATE REC'D BY LOCAL REG. <b>9-23-54</b>	REGISTRAR'S SIGNATURE <b>Mrs. Ella Hunter</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Weld Funeral Home - Sikeston Mo.</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DATE-RECEIVED SEP 27 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No. 954-198

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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 Linton .....

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.