

3593

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 11 1955

Registrar's No. 15

BIRTH NO.		REG. DIST. NO. <u>333</u>		PRIMARY REG. DIST. NO. <u>3074</u>		Registrar's No. <u>15</u>			
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>New Madrid</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>5 Days</u>		c. CITY OR TOWN <u>Portageville</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 (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>Route 3</u>				<u>0720</u> <u>1</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Berta</u>			b. (Middle) <u>-----</u>		c. (Last) <u>Hart</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 23 1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>2-8-1891</u>		9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days 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>01</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Benton, Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Dan Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Fannie Bowden</u>			14. NAME OF HUSBAND OR WIFE <u>Henry Hart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Henry Hart, Portageville, Missouri</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic C-V disease</u>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Left sided hemiplegia</u>				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>4221</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>1-18</u> , 19 <u>55</u> , to <u>1-23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1-23</u> , 19 <u>55</u> , and that death occurred at <u>10:53 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree as title) <u>Aldea Sargent MD</u>						23b. ADDRESS <u>Sikeston, Missouri</u>		23c. DATE SIGNED <u>1-24-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>1-26-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mounts Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Libbourn Mo</u>				
DATE REC'D BY LOCAL REG. <u>2-3-55</u>		REGISTRAR'S SIGNATURE <u>Mr. C. L. Hunter</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert Funeral Home</u>		ADDRESS <u>Portageville</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

0030

DATE RECEIVED FEB 7 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 255-27

FEB 28 1955

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.....

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.