

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10-48

FILED JAN 21 1955

BIRTH NO. 94621-54 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 2

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

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>1 Day</u>		c. CITY OR TOWN <u>Matthews</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>				* STREET ADDRESS (If rural, give location) <u>Route 2</u> <u>0750</u> <u>1</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Annie</u>			b. (Middle) <u>Pearl</u>		c. (Last) <u>Nelson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>1</u> <u>1955</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>12-31-1954</u>		9. AGE (In years last birthday) <u>-</u> IF UNDER 1 YEAR Months <u>-</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>-</u>	
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, Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Johnny Nelson</u>				13b. MOTHER'S MAIDEN NAME <u>Annie Jane Cole</u>			14. NAME OF HUSBAND OR WIFE <u>0</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 ADDRESS <u>Mrs. Annie Nelson, Matthews, 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>Atelectasis Congenital</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>I. PREMATURE SEPARATION OF PLACENTA.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>7620</u>						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)				
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>12-31</u> , 19 <u>54</u> , to <u>1-1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1-1</u> , 19 <u>55</u> , and that death occurred at <u>6:05 A. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Anna B. Smith M.D.</u>				23b. ADDRESS <u>Sikeston, Mo.</u>				23c. DATE SIGNED <u>1-4-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-3-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Carpenter</u>		24d. LOCATION (City, town, or county) (State) <u>N.W. Sikeston, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>1-10-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ella F. ...</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Fred Smith 1212 Mand St.</u>				

DATE RECEIVED JAN 17 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 155-10

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 Fred J. Smith
Licensed Embalmer No.....

P. O. Address Litkinton

Not Embalmed

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.