

FILED FEB 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6954

State File No.

3074 Registrar's No. 19

BIRTH NO. REG. DIST. NO. 333 PRIMARY REG. DIST. NO.

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| 1. PLACE OF DEATH a. COUNTY Scott | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri | | b. COUNTY New Madrid | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston | | c. CITY OR TOWN Catron | | d. 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 (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Mo. Delta Community Hospital | | | | | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) Clarence | | | b. (Middle) Leroy | | | c. (Last) Mims | | | 4. DATE OF DEATH (Month) (Day) (Year) 2 2 1955 | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH 2-2-1892 | | | 9. AGE (In years last birthday) 63 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | | | 11. BIRTHPLACE (City and State or Foreign Country) Missouri | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |

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| 13a. FATHER'S NAME Clarence Mims | | | 13b. MOTHER'S MAIDEN NAME Kate Turner | | | 14. NAME OF HUSBAND OR WIFE Lillie Lewis | | | | | |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | 16. SOCIAL SECURITY NO. <input type="checkbox"/> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Alva Kirk, Catron, Mo. | | | | | | | |
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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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Membranous, Central, Meninge | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension, Essential unknown | | | | | | | | | |
| | | DUE TO (c) | | | | | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | | | |

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| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 331X | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (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 **2-2-55**, 19 **55**, to **2-2**, 19 **55**, that I last saw the deceased alive on **2-2**, 19 **55**, and that death occurred at **9:10 A. m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) Clarence B. Smith M.D. | | | | 23b. ADDRESS Sikeston, Missouri | | | | 23c. DATE SIGNED 2-4-55 | | | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE Feb 6 1955 | | 24c. NAME OF CEMETERY OR CREMATORY Taylor Cemetery | | | | 24d. LOCATION (City, town, or county) (State) Plumerville Mo | | | |
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| DATE REC'D BY LOCAL REG. 2-10-55 | | REGISTRAR'S SIGNATURE Mrs. Ella Hunter | | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The First Funeral Parlor Portageville Mo | | | | | |
|-----------------------------------------|--|-----------------------------------------------|--|--|--|------------------------------------------------------------------------------------------|--|--|--|--|--|

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

DATE RECEIVED FEB 14 1955
SCOTT CO. HEALTH DEPT.
CO. FILE No. 255-31

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 Joseph A. [Signature]
Licensed Embalmer No. 448
P. O. Address Tokgerville

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.