

FILED MAY 9 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

MILLS

14394

State File No.

BIRTH NO.

REG. DIST. NO. 333

PRIMARY REG. DIST. NO. 3074

Registrar's No.

57

1003

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

1. PLACE OF DEATH a. COUNTY <b>SCOTT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>SCOTT</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>SIKESTON</b>		c. LENGTH OF STAY (in this place) <b>32 yrs</b>	c. CITY OR TOWN <b>SIKESTON</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>704 MATTHEWS</b>		STREET ADDRESS (If rural, give location) <b>704 MATTHEWS</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>MAUDE</b> b. (Middle) <b>ELIZABETH</b> c. (Last) <b>AGEE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>4-24-1955</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-19-1882</b>
9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.	11. BIRTHPLACE (City and State or Foreign Country) <b>RECTOR ARKANSAS</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>JOHN SANFORD</b>		13b. MOTHER'S MAIDEN NAME <b>ELIZABETH PAGE</b>	14. NAME OF HUSBAND OR WIFE <b>C. A. Agee</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT'S SIGNATURE OR NAME <b>C. A. Agee - Sikeston Mo</b>
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>MALIGNANT CARCINOMA of sigmoid</b> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>—</b> DUE TO (c) <b>—</b> 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 <b>153X</b>	
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) (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 <b>4/24</b> , 19 <b>55</b> , to <b>4/24</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>4/24</b> , 19 <b>55</b> , and that death occurred at <b>6:30 A. M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Melville DODD</b> (Degree or title)		23b. ADDRESS <b>Sikeston Mo</b>	
23c. DATE SIGNED <b>4/25/55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>4-26-55</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>GARDEN OF MEMORIES</b>		24d. LOCATION (City, town, or county) (State) <b>SIKESTON MO</b>	
DATE REC'D BY LOCAL REG. <b>4-26-55</b>		REGISTRAR'S SIGNATURE <b>Mrs. Clara Hunter</b> <b>429</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Welsh Funeral Home</b>		ADDRESS <b>Sikeston Mo</b>	

(Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED MAY 2 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 555-93

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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.