

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Scott	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston,		c. CITY OR TOWN Sikeston,	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 25 yr.		e. STREET ADDRESS (If rural, give location) Bowman St	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bowman Street			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Nannie	b. (Middle) XXXXXXXX	c. (Last) White	(Month) December	(Day) 30,	(Year) 1955
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 20, 1882	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 7 Days 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 0		10b. KIND OF BUSINESS OR INDUSTRY House	11. BIRTHPLACE (City and State or Foreign Country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Single
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 0 XXXX	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Laura Mason 226 Young St. Sikeston Mo

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ess. Hypertension		
	DUE TO (c) —		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331x			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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 July 2, 1955, to 12-30-55, that I last saw the deceased alive on Aug. 2, 1955, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. D. Urban M. D.	23b. ADDRESS Sikeston	23c. DATE SIGNED 1-3-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-1-56	24c. NAME OF CEMETERY OR CREMATORY Smith West End Court West of Sikeston Mo.	24d. LOCATION (City, town, or county) (State) Mo.
DATE REC'D BY LOCAL REG. 1-3-56	REGISTRAR'S SIGNATURE Mrs. Clara Hunter 429	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Red J. Smith 1212 Main St.	

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

DATE RECEIVED JAN 9 1956

SCOTT CO. HEALTH DEPT.

CO. FILE No. 156-10

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 Ludwig Smith
Licensed Embalmer No. 718

P. O. Address Sikeston

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.