

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12020**

**FILED APR 16 1956**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. **60**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Scott</b>  b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sikeston</b>  c. LENGTH OF STAY (in this place) <b>8 Hours</b>  d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mo. Delta Community Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>  c. CITY OR TOWN <b>Matthews</b>  d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  e. STREET ADDRESS (If rural, give location) <b>Route #3</b> <span style="float: right;"><b>07201</b></span>	
<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Roy</b> b. (Middle) <b>—</b> c. (Last) <b>Daniels</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>4 3 1956</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>3-25-1909</b>
<b>9. AGE</b> (In years last birthday) <b>47</b>	IF UNDER 1 YEAR Months Days Hours Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>
<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Wayne Co., Tennessee</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>J. C. Daniels</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Minnie Brewer</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Alta Reed</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>J. R. Daniels, Matthews, Mo.</b>	

<b>18. CAUSE OF DEATH</b> 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.	<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <i>Rheumatic Heart Disease</i>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 days</b>
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>4/6x</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>

**22. I hereby certify that I attended the deceased from 4-1, 1956 to 4-3, 1956 that I last saw the deceased alive on 4-3, 1956, and that death occurred at 6:05 P.m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <i>J. R. Daniels</i>	(Degree or title) <b>M.D.</b>	<b>23b. ADDRESS</b> <b>Morehouse, Missouri</b>	<b>23c. DATE SIGNED</b> <b>4-4-56</b>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>REMOVAL</b>	<b>24b. DATE</b> <b>4-5-56</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>City</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>LAWRENCE BEAG TENN</b>
<b>DATE REC'D BY LOCAL REG.</b> <b>4-4-56</b>	<b>REGISTRAR'S SIGNATURE</b> <i>Mrs. Colla Hunter</i>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Weld Funeral Home - Sikeston Mo</i>	

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

DATE RECEIVED APR 9 1956

SCOTT CO. HEALTH DEPT.

CO. FILE No. 456-86

**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. 34

P. O. Address Litton

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.