

FILED JAN 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3377

BIRTH NO. _____ REG. DIST. NO. 323 PRIMARY REG. DIST. NO. 6115 Registrar's No. 8

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

1. PLACE OF DEATH a. COUNTY SCOTT		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give town) RICHLAND		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Hwy 60 Scott		c. CITY (If outside corporate limits, write RURAL and give township) SIKESTON	
		d. STREET ADDRESS (If rural, give location) 418 COLEMAN	
3. NAME OF DECEASED (Type or Print) a. (First) DRURY		b. (Middle) AUSTIN	
		c. (Last) WAKE	
4. DATE OF DEATH (Month) (Day) (Year) 1-12-1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 10-18-1914
9. AGE (In years last birthday) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR	11. BIRTHPLACE (State or foreign country) MO
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME JAMES HENRY WAKE		13b. MOTHER'S MAIDEN NAME LEOLA WATKINS	
14. NAME OF HUSBAND OR WIFE VIVIAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 496-05-1080	
17. INFORMANT'S SIGNATURE OR NAME Mrs Vivian Wake - Sikeston Mo		ADDRESS	
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) Fractured Skull left Frontal 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hwy 60 Near Gray Kn...	
21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) Scott MO		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan. 12, 57, 5:30 pm	
21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Hit from behind by station wagon + thrown from pickup truck	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at about 5:45 pm. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Thelma E. Buckthorp - M.D. Health Officer		23b. ADDRESS Benton, Mo.	
23c. DATE SIGNED 1-17-57			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 1-15-57	
24c. NAME OF CEMETERY OR CREMATORY GARDEN OF MEMORIES		24d. LOCATION (City, town, or county) (State) SIKESTON MO	
DATE REC'D BY LOCAL REG. 1-18-57		REGISTRAR'S SIGNATURE Mrs. Edw. Hunter	
25. FUNERAL DIRECTOR'S SIGNATURE Welch Funeral Home - Sikeston Mo		ADDRESS	

DATE RECEIVED JAN 21 1957

SCOTT CO. HEALTH DEPT.

CO. FILE NO. 157-11

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
Student Embalmer

Signed Raymond S. Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

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 this body is not embalmed, fact should be so stated above.