FILED MAR 4 1957

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 3947

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 150

1. PLACE OF DEATH
a. COUNTY Cape GIRARDEAU
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Ostapathic — Length of stay in Ib 5 Dys

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Mississippi
c. CITY OR TOWN East Prairie, 0641 — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 310 S. Center — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First: Minnie Middle: Francis Last: Bibb

4. DATE OF DEATH Month: Feb. Day: 4, Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 15, 1896

9. AGE (In years last birthday): 60 — 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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (City and state or country): Flat Creek, Mo. 0

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Potter

14. MOTHER'S MAIDEN NAME: Florence Redding

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No - - - - - - - - - -

16. SOCIAL SECURITY NO.: - - - -

17. INFORMANT: John Bibb — Address: East Prairie, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypostatic pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Circulatory failure, Shock
DUE TO (c) Surgery.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1-30-57 to 2-4-57 and last saw her alive on 2-4-57
Death occurred at 10 o'clock a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L. W. Higgins D.O.

22b. ADDRESS Cape Girardeau Mo.

22c. DATE SIGNED 2-22-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 2/6/1957

23c. NAME OF CEMETERY OR CREMATORY I. O. O. F.

23d. LOCATION (City, town, or county) (State) Charleston, Mo.

24. FUNERAL DIRECTOR Mc Mikle ADDRESS East Prairie, Mo.

25. DATE RECD. BY LOCAL REG. 2-26-1957

26. REGISTRAR'S SIGNATURE C. C. Summers

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed J. E. McMahle

Licensed Embalmer No. 46

P. O. Address East Pre

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