

Health, Welfare, Public Service

300 1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms which are listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 25 1957

7213

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missour</b> b. COUNTY <b>Mississippi</b> c. CITY OR TOWN <b>East Prairie Mo.</b> d. STREET ADDRESS <b>Gen. Del.</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>East Prairie Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bel-Air Nursing Home</b>				Length of stay in 1b <b>6 days</b>		d. STREET ADDRESS (If outside, give location) <b>Gen. Del.</b>		
3. NAME OF DECEASED (Type or print) <b>Mollie M. Kell</b>				4. DATE OF DEATH <b>Feb. 7-57</b>		5. SEX <b>Female</b>		
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 8-1885</b>		9. AGE (In years last birthday) <b>71</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Charleston Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Mark Milliner</b>				14. MOTHER'S MAIDEN NAME <b>Martha Floyd</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>0</b>		17. INFORMANT <b>Lawrence Kell East Prairie Mo.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebrovascular accident</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>About 18 hr</b>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)					20e. CITY, TOWN, OR LOCATION <b>331x</b>
20f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20g. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20h. CITY, TOWN, OR LOCATION		20i. COUNTY	
21. I attended the deceased from <b>2-1</b> to <b>57</b> and last saw her alive on <b>2-7-57</b> Death occurred at <b>10:00 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>E. D. Wilson</b> (Degree or title)				22b. ADDRESS <b>M. D. Sikeston</b>		22c. DATE SIGNED <b>2-12-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-9-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oddfellows</b>		23d. LOCATION (City, town, or county) (State) <b>Charleston Mo.</b>		
24. FUNERAL DIRECTOR <b>Travis Shelby East Prairie Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>2-12-57</b>		26. REGISTRAR'S SIGNATURE <b>Max. Oscar Hunt</b>		

(Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED FEB 18 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 257-39

MAR 8  
FEB 19 1959

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 *Travis Shelby Jr.*

Licensed Embalmer No. 49

P. O. Address *East. Pa.*

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.