

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15848**

FILED APR 26 1957

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 66	
1. PLACE OF DEATH a. COUNTY Scott				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Mississippi			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston		c. LENGTH OF STAY (in this place) 132 Days		c. CITY OR TOWN Charleston		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Mo. Delta Community Hospital				e. STREET ADDRESS (If rural, give location) 713 S. Main St.			
3. NAME OF DECEASED (Type or Print) a. (First) Maud		b. (Middle) _____		c. (Last) Cain		4. DATE OF DEATH (Month) 4 (Day) 10 (Year) 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7-31-1884		9. AGE (In years last birthday) 72	# UNDER 1 YEAR Months _____ Days _____	# 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 Foreign Country) Charleston, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME George Rowe		13b. MOTHER'S MAIDEN NAME Elizabath Elmore		14. NAME OF HUSBAND OR WIFE George Cain			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 0		16. SOCIAL SECURITY NO. 0		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Betty Rister, Charleston, 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.		<p align="center">MEDICAL CERTIFICATION</p> <p>1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Myotrophic lateral Sclerosis, bulbar type.</i></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.</p>					INTERVAL BETWEEN ONSET AND DEATH 14 mo.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		3561		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)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on 4/19 , 19 57 , and that death occurred at 2:45A. m., from the causes and on the date stated above.							
23a. SIGNATURE <i>William J. Bingham</i> (Degree or title) MD.				23b. ADDRESS Sikeston, Mo.		23c. DATE SIGNED 4/11/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/11/57	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		24d. LOCATION (City, town, or county) (State) Charleston, Mo.		
DATE REC'D BY LOCAL REG. 4-15-57		REGISTRAR'S SIGNATURE <i>Anna Ella Hunter</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>John P. Nunnelee</i> The Nunnelee Funeral Chapel			

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

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DATE RECEIVED APR 22 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 457-89

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 *John F. [Signature]*

Licensed Embalmer No. 3857

P. O. Address Charleston

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.