

FILED JUL 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27163

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <b>333</b>		PRIMARY REG. DIST. NO. <b>3074</b>		Registrar's No. <b>112</b>							
1. PLACE OF DEATH a. COUNTY <b>SCOTT</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>SCOTT</b>									
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>SIKESTON</b> )		c. LENGTH OF STAY (in this place) <b>23 YRS</b>		c. CITY OR TOWN <b>SIKESTON</b>		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>220 YOUNG ST.</b>				e. STREET ADDRESS (If rural, give location) <b>220 YOUNG ST.</b>									
3. NAME OF DECEASED (Type or Print) a. (First) <b>HENRY</b>			b. (Middle) <b>-</b>		c. (Last) <b>REED</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>7 5 57</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>MAY 11, 1892</b>		9. AGE (In years last birthday) <b>65</b>		IF UNDER 1 YEAR Months Days		IF UNDER 12 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AGRI.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>COMO, MISS.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13a. FATHER'S NAME <b>UNKNOWN</b>				13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				14. NAME OF HUSBAND OR WIFE <b>EMMA REED</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>JOHN HENRY REED SIKESTON</b>							
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) <b>Hypertensive C-V Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>when</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized Arteriosclerosis</b>										<b>when</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 <b>443x</b>										20. AUTOPSY? <b>2</b> 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) (Min.) _____		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 <b>25 Jan</b> , 1952, to <b>5 July</b> , 1957, that I last saw the deceased alive on <b>5 July</b> , 1957, and that death occurred at _____ m., from the causes and on the date stated above.													
23a. SIGNATURE <b>John L. Sample M.D.</b> (Degree or title)						23b. ADDRESS <b>Sebastian Mo</b>				23c. DATE SIGNED <b>10 Jul 57</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>JULY 7</b>		24c. NAME OF CEMETERY OR CREMATORY <b>SUNSET</b>				24d. LOCATION (City, town, or county) (State) <b>SIKESTON MO.</b>					
DATE REC'D BY LOCAL REG. <b>13 July 57</b>				REGISTRAR'S SIGNATURE <b>Mrs. Ella Hunter</b>				25 FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>ALVIN DOTSON, 220 WEST GATE</b>					

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

29-0

DATE RECEIVED JUL 15 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 757-140

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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 Tris D. Marshall

Licensed Embalmer No. 460

P. O. Address .....

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.