

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**30538**

State File No. ....

**FILED AUG 16 1957**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. **131**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Scott</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sikeston</b>		c. CITY OR TOWN <b>Morehouse</b>	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>5 HOURS</b>		e. STREET ADDRESS (If rural, give location) <b>720</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Mo. Delta Community Hospital</b>			

<b>3. NAME OF DECEASED</b> (Type or Print)	a. (First) <b>Wendy</b>	b. (Middle) <b>Vana</b>	c. (Last) <b>McNew</b>	<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>7 29 1957</b>
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7-29-1957</b>	<b>9. AGE</b> (In years last birthday) <b>5</b> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 10 MIN. Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Sikeston, Mo.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>Ivan B. McNew, Jr.</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Peggy Jines</b>	<b>14. NAME OF HUSBAND OR WIFE</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)	<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Ivan McNew, Morehouse, Mo.</b>	<b>ADDRESS</b>
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<b>18. CAUSE OF DEATH</b> 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.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>ABNORMAL PULMONARY VENTILATION</b>		<b>6 hrs</b>
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Anoxia</b> DUE TO (c)		<b>10 hrs</b>
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		<b>1. PREMATUREITY</b> <b>2. PREMATURE SEPARATION PLACENTA</b>	

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>7615</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <b>Sikeston, Mo.</b>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from 7-29, 1957, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on 7-29, 1957, and that death occurred at 11:00 P. m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <i>[Signature]</i>	(Degree or title) <b>MD</b>	<b>23b. ADDRESS</b> <b>Sikeston, Mo.</b>	<b>23c. DATE SIGNED</b> <b>8-2-57</b>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify)	<b>24b. DATE</b> <b>8-4-1957</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Fellow Cemetery</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>Totton, Mo.</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>8-3-57</b>	<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>	<b>ADDRESS</b> <b>Sikeston, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

DATE RECEIVED AUG 12, 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 857-174

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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 Body Not Embalmed  
Licensed Embalmer No.....

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.