

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30550

FILED AUG 16 1957

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 6115 Registrar's No. 136

1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Scott</u>															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>R. 7. D. 4 (Sikeston)</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>R. 7. D. 4</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R. 7. D. 4</u>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>R. 7. D. 4</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <u>Jeanlah Myrtle</u> Middle <u>Hargrove</u> Last <u>Hargrove</u>				4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1957</u>															
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb 15, 1917</u>		9. AGE (In years last birthday) <u>40</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (City and state or country) <u>Deering, Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Hargrove</u>				14. MOTHER'S MAIDEN NAME <u>Emma McCall</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —				16. SOCIAL SECURITY NO. —				17. INFORMANT Address <u>Robert Hargrove Vankuser, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC DECOMPENSATION</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>							
DUE TO (b) <u>EMYOCARDOSIS - ARTERIOSCLEROSIS 1 YR.</u>																			
DUE TO (c) _____																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHIECTASIS, EMPHYSEMA</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>NATURAL</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>															
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____																			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>				20f. CITY, TOWN, OR LOCATION —				COUNTY _____ STATE _____							
21. I attended the deceased from <u>4-13-57</u> to <u>7-8-57</u> and last saw her ^{her} _{him} alive on <u>7-8-57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <u>H. Imsebach, D.O.</u>						22b. ADDRESS <u>Chaffee, Mo.</u>						22c. DATE SIGNED <u>8-7-57</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE <u>7-18-57</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>				23d. LOCATION (City, town, or county) (State) <u>Malden, Mo.</u>							
24. FUNERAL DIRECTOR <u>Cheriton Funeral Home</u> <u>Sikeston, Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>8-8-57</u>						26. REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>							

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DATE RECEIVED AUG 12 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 857-170

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by; Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Carl J. Smith*

Licensed Embalmer No. 26

P. O. Address *Oran*

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.