

FILED NOV 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38848

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 187

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <u>Scott</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Scott</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Sikeston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hosp.</u>		Length of stay in 1b <u>3 Days</u>		d. STREET ADDRESS (If outside, give location) <u>1302 Maud St.</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First <u>Dave</u> Middle <u>-</u> Last <u>Lenard</u>				Month <u>10</u> Day <u>21</u> Year <u>1957</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>0</u> Days <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>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Monroe, Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Newt Lenard</u>				14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT Address <u>Mr. L. T. Wiggins, Sikeston, 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>Edema, pulmonary</u> DUE TO (b) <u>Hypertensive Encephalopathy</u> DUE TO (c) <u>Malignant Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>334X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>3 days</u> <u>2 years</u>	
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.)		
20c. TIME OF INJURY Hour <u>11:50</u> Month, Day, Year <u>10-21-57</u> a. m. <u>P.</u> 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>10-19-57</u> to <u>10-21-57</u> and last saw ^{him} alive on <u>10-21-57</u> Death occurred at <u>11:50</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Type or print) <u>[Signature]</u>				22b. ADDRESS <u>Sikeston, Mo.</u>		22c. DATE SIGNED <u>10-23-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10 27 57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET</u>		23d. LOCATION (City, town, or county) (State) <u>SIKESTON Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>ALVIN DOTSON SIKESTON, MO</u>		25. DATE RECD. BY LOCAL REG. <u>10-28-59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

Health,
& Welfare
Public
Service300
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

29-0

DATE RECEIVED NOV 4, 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1157-233

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.....

Frank S. Mansfield

Licensed Embalmer No. 460

P. O. Address St. Helens

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.