

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008483
STATE FILE NUMBER

FILED FEB 28 1958

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 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>2 Days</u>		d. STREET ADDRESS (If outside, give location) <u>115 South St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Hester</u> Middle <u>—</u> Last <u>McConnell</u>			4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-1892</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		100. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>Witley Co., Tennessee</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rieley Gray</u>			14. MOTHER'S MAIDEN NAME <u>Phoobe Warren</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>0</u>		16. SOCIAL SECURITY NO. <u>0</u>	17. INFORMANT Address <u>June Rodgers, 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>pulmonary infarct</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>Several yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Essential Hypertension with</u>	
	DUE TO (c) <u>Cardiac DeCompensation</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>443 X</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"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>443 X</u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u> STATE <u> </u>

21. I attended the deceased from <u>2-17-58</u> to <u>2-19-58</u> and last saw her ^{her} him alive on <u>2-19-58</u> Death occurred at <u>4:15</u> <u>A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>E. D. Urban M.D.</u> (Degree or title)	22b. ADDRESS <u>Sikeston</u> <u>Morehouse, Mo.</u>	22c. DATE SIGNED <u>2/21/58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-21-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LYNNVILLE, KY</u>	23d. LOCATION (City, town, or county) (State) <u>LYNNVILLE, KY</u>
24. FUNERAL DIRECTOR ADDRESS <u>MEMPHIS FUNERAL HOME</u> <u>CHARLESTON, MO</u>		25. DATE RECD. BY LOCAL REG. <u>2-21-58</u>	26. REGISTRAR'S SIGNATURE <u>Miss Ella Henderson</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

DATE RECEIVED FEB 24 1958

SCOTT CO. HEALTH DEPT.

CO. FILE No. 258-54

STATEMENT BY LICENSED EMBALMER

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

Student.....
Signature of Student Embalmer

Signed *[Handwritten Signature]*
.....

Licensed Embalmer No. *[Handwritten Number]*

P. O. Address *[Handwritten Address]*

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.