

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012850

STATE FILE NUMBER

FILED APR 4 1958

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 48

Health, Welfare, Public Service

300
9-56

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

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>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Morehouse</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 lb <u>2 Days</u>	d. STREET ADDRESS (If outside, give location) <u>—</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>First Belle Middle Allen Last Hearon</u>			4. DATE OF DEATH Month <u>3</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>12-24-1875</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 <u>—</u>	11. BIRTHPLACE (City and state or country) <u>Union Co., Kentucky</u>
13. FATHER'S NAME <u>James Allen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Coffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>N. W. Hearon, Morehouse, Mo.</u> Address
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>Acute Myocardial Infarction</u> <u>ASHD.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ASHD.</u> DUE TO (c) <u>4200H</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of Cervix - 2 years</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>2</u>		
20c. TIME OF INJURY Hour <u>—</u> Month <u>—</u> Day <u>—</u> a. m. <u>—</u> p. m. <u>—</u>		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>—</u>		20f. CITY, TOWN, OR LOCATION <u>Morehouse, Mo.</u> COUNTY <u>—</u> STATE <u>—</u>	
21. I attended the deceased from <u>7/7/57</u> to <u>3/19/58</u> and last saw her/him alive on <u>3/19/58</u> Death occurred at <u>10:35</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Sign in or title) <u>Ralph Franklin, M.D.</u>		22b. ADDRESS <u>Morehouse, Mo.</u>	22c. DATE SIGNED <u>3/22/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/22/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Sikeston, Mo.</u>
24. FUNERAL DIRECTOR <u>Abelton Funeral Home</u> <u>Sikeston, Mo.</u>		ADDRESS <u>—</u>	25. DATE RECD. BY LOCAL REG. <u>3-24-58</u>
		26. REGISTRAR'S SIGNATURE <u>Mr. E. H. Hunter</u>	

(Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED MAR 31 1958

SCOTT CO. HEALTH DEPT.

CO. FILE No. 358-82

STATEMENT BY LICENSED EMBALMER

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

Student.....
Signature of Student Embalmer

Signed Earl J. Smith.....

Licensed Embalmer No. 267

P. O. Address Van, Va

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.