

Health, Welfare, Public Service

300 1-56

Director, coroner, etc. must use only standard nomenclature in Part 18. No symptoms will be listed. All diseases in Part 1 must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012865

STATE FILE NUMBER

FILED MAR 21 1958

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 39

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>Scott</u> <u>1003</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) <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 lb <u>4 Hrs.</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Ed</u> Middle <u>-</u> Last <u>Winter</u>				4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>1958</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 type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-15-1900</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAFE WORK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>Tiptonville, Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Winter</u>				14. MOTHER'S MAIDEN NAME <u>Luvania Gaines</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>			16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>LAURA TAYLOR</u>		Address <u>SEATTLE WASH.</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>Cerebrovascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Ess. Hypertension</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>331X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>?</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.) <u>0</u>							
20c. TIME OF INJURY Hour <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> </u>	COUNTY <u> </u>	STATE <u> </u>
21. I attended the deceased from <u>2-22-58</u> to <u>2-23-58</u> and last saw ^{her} him alive on <u>2-22-58</u> Death occurred at <u>3:40</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>				22b. ADDRESS <u>Sikeston, Mo.</u>		22c. DATE SIGNED <u> </u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>2-26-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset</u>		23d. LOCATION (City, town, or county) <u>SIKESTON</u>		(State) <u>MO.</u>			
24. FUNERAL DIRECTOR <u>Alvin Dabson</u>			ADDRESS <u>Sikeston, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-10-58</u>		26. REGISTRAR'S SIGNATURE <u>Miss Ellen Hunter</u>			

DATE RECEIVED MAR 17 1958

SCOTT CO. HEALTH DEPT.

CO. FILE No. 358-66

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 Fris S. Marshall.....

Licensed Embalmer No. 46.....

P. O. 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.