

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015085

STATE FILE NUMBER

FILED MAY 15 1958

Registration District No. 242 Primary Registration District No. 4361 Registrar's No. 2d 8

1. PLACE OF DEATH a. COUNTY <b>NEW MADRID</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>New Madrid</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>RURAL</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>RURAL</b> <b>0729</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CANALOU TWP.</b> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>CANALOU TWP.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hudrey</b> Middle <b>Betty</b> Last <b>HUNTER</b>			4. DATE OF DEATH Month <b>4</b> Day <b>11</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC-5-1910</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	9c. AGE (In years last birthday) <b>47</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>Ironton Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM BLANKENSHIP</b>	
14. MOTHER'S MAIDEN NAME <b>NANCIE JOHNSON</b>		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. <b>495-14-2880</b>		17. INDEORMANT Address <b>Elmer Stutler, Egan MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cervical Carcinoma with Metastasis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>171X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			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.)		
20c. TIME OF INJURY: Hour _____ Month, _____ Day, _____ 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.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. I attended the deceased from <b>1/6/58</b> to <b>1/24/58</b> and last saw her alive on <b>1/24/58</b> Death occurred at <b>2:22 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Alfred Berent</b>		22b. ADDRESS <b>707 Tanner St., Sikeston, Mo.</b>	22c. DATE SIGNED <b>4/12/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4-12-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Matthew's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Matthew MO.</b>
24. FUNERAL DIRECTOR <b>Welsh Funeral Home</b> ADDRESS <b>Sikeston Mo</b>	25. DATE RECD. BY LOCAL REG. <b>4-28-58</b>	26. REGISTRAR'S SIGNATURE <b>Kathryn L. McBain</b>	

(Licensed Embalmer's Statement on Reverse Side)

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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.  
USE ONLY BLACK INK OR RIBBON, TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

MAY 16 1958

DATE RECEIVED MAY 5 1958

NEW MADRID CO. HEALTH CENTER

E.S.

MAY 15 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision..

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 340

P. O. Address Sikeston

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.