

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024279
STATE FILE NUMBER

FILED JUN 20 1958 Registration District No. 333 Primary Registration District No. 8074 Registrar's No. 100

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 type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>New Madrid</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>5 Hrs.</u>		d. STREET ADDRESS (If outside, give location) <u>702 Mitchell St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lavonda</u> Middle <u>Sue</u> Last <u>Henry</u>			4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-1957</u>	9. AGE (In years last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) <u>Hot Springs Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Henry</u>			14. MOTHER'S MAIDEN NAME <u>Doris Wren</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Doris Henry, New Madrid, 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>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dehydration</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.)	
20c. TIME OF INJURY Hour <u>10:28</u> Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT <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>6/2/58</u> to <u>6/2/58</u> and last saw <u>her</u> him alive on <u>6/2/58</u> Death occurred at <u>10:28</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Wm. C. Critchlow M.D.</u>	22b. ADDRESS <u>Sikeston, Mo.</u>	22c. DATE SIGNED <u>June 7, 1958</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4 June 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>near New Madrid, Mo</u>
24. FUNERAL DIRECTOR <u>Richards Undt Co. New Madrid, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6-10-58</u>	26. REGISTRAR'S SIGNATURE <u>Maxella Hunter</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Service

300 1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

DATE RECEIVED 6-16-58

SCOTT CO. HEALTH DEPT.

CO. FILE NO. 658-140

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 Tammy S. Roberts.....

Licensed Embalmer No. 48.....

P. O. Address New Madrid.....

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.