

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024289  
STATE FILE NUMBER

FILED JUN 20 1958 Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 103

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Charleston</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>Mo. Delta Comm. Hosp.</b> Length of stay in 1b <b>30 Min.</b>		d. STREET ADDRESS (If outside, give location) <b>218 N. Elm St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Warford</b> Middle <b>E.</b> Last <b>Small</b>	4. DATE OF DEATH Month <b>6</b> Day <b>4</b> Year <b>1958</b>
--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-22-1879</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
--------------------	-------------------------------	---	------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Jordan St., Kentucky</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	-----------------------------------	--	---

13. FATHER'S NAME <b>Eldora Small</b>	14. MOTHER'S MAIDEN NAME <b>Lou Visa</b>
---------------------------------------	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>0</b> (If yes, give war or dates of service) <b>0</b>	16. SOCIAL SECURITY NO. <b>2</b>	17. INFORMANT Address <b>Fannie Small, Charleston, 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>Sept. Anemysis abd aorta</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>451X</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sensitivity - arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ Year _____ a. m. _____ p. m. _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	---	------------------------------	--------	-------

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 **on 6-4-58** and last saw **not** him alive on **6-4-58**  
Death occurred at **11:25 A. m** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>E. Charles Downing M.D.</b>	22b. ADDRESS <b>Charleston, Mo.</b>	22c. DATE SIGNED <b>6-6-58</b>
---	-------------------------------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/6/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Charleston, Mo.</b>
---	-------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <b>The Nunnelee Funeral Chapel Charleston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-13-58</b>	26. REGISTRAR'S SIGNATURE <b>Miss Ella Hunter</b>
---	---	---

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

DATE RECEIVED

6-16-58

SCOTT CO. HEALTH DEPT.

CO. FILE No.

658-143

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 Edward E. [Signature]

Licensed Embalmer No. 416

P. O. Address Seheston,

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