

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024802

STATE FILE NUMBER

FILED AUG 6 1958

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 172

1. PLACE OF DEATH a. COUNTY <b>CALLAWAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>MISSOURI</b> b. COUNTY <b>NEW MADRID</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FULTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>PORTAGEVILLE</b> <u>0 22 0</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ST. HOSPITAL #1		Length of stay in lb <b>8mo. 23 da</b>	d. STREET ADDRESS (If outside, give location) <b>P.O. BOX 182</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES SIKES</b>			4. DATE OF DEATH Month Day Year <b>JULY 28, 1958</b>
5. SEX <b>MALE 2</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-17-1892</b>
9. AGE (In years (last birthday) <b>66</b> )		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	11. BIRTHPLACE (City and state or country) <b>MISSISSIPPI 1</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>GEORGE SIKES</b>	
13b. MOTHER'S MAIDEN NAME <b>SARAH FORD</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>ST. HOSPITAL #1, FULTON, MISSOURI</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>Subarachnoid Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <b>330 X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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. 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. <b>Xst Hospital</b> attended the deceased from <b>11-5-57</b> to <b>7-28-58</b> and last saw <sup>her</sup> him alive on <b>7-28-58</b> Death occurred at <b>10:00 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>Ernest Schonhardt, MD</b>		22b. ADDRESS <b>St. Hospital #1</b>	22c. DATE SIGNED <b>7-28-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>7/29/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>Columbia Mo.</b>
24. FUNERAL DIRECTOR <i>[Signature]</i> ADDRESS <b>Columbia Mo</b>	25. DATE RECD. BY LOCAL REG. <b>July 29, 1958</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

**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 .....

Licensed Embalmer No.....

P. O. Address.....

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