

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027910
STATE FILE NUMBER

FILED JUL 25 1958 Registration District No. 333 Primary Registration District No. 3079 Registrar's No. 133

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR Sikeston Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Matthews 6720 Inside Limits 0 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) Length of stay in lb HOSPITAL OR Mo. Delta Comm. Hosp. 1 Hr.		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 Deene Middle --- Last Reid			4. DATE OF DEATH Month 7 Day 12 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1903	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Hours 1 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	10b. KIND OF BUSINESS OR INDUSTRY Public School	11. BIRTHPLACE (City and state or country) Florence, Alabama	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME John Whitten	14. MOTHER'S MAIDEN NAME Fannie Gardner
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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. ---	17. INFORMANT Mr. Ellis V. Reid, Matthews, Mo.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) cardiac decompensation	
	DUE TO (c) Hypertensive heart disease.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 443X		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, Year 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 Sikeston, Mo.	COUNTY	STATE
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21. I attended the deceased from **1950** to **7-12-58** and last saw her ^{her} _{him} alive on **7-12-58**
Death occurred at **4:45** **A.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE E. D. Urban, M.D. (Degree or title)	22b. ADDRESS Sikeston, Mo.	22c. DATE SIGNED 7-16-58
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-14-58	23c. NAME OF CEMETERY OR CREMATORY Matthews Cem. Matthews Mo.	23d. LOCATION (City, town, or county) (State) Mo.
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24. FUNERAL DIRECTOR Christman Funeral Home	ADDRESS Sikeston, Mo	25. DATE RECD. BY LOCAL REG. 7-19-58	26. REGISTRAR'S SIGNATURE Max Ella Hunter
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(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service 03 300 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

DATE RECEIVED 7-21-58

SCOTT CO. HEALTH DEPT.

CO. FILE NO. 258-178

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 Earl J. Smith.....

Licensed Embalmer No. 267

P. O. Address Rawl.....

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: