Health, Welfare Public Service
3
1
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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031461
STATE FILE NUMBER

FILED SEP 5 1958 Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 163

1. PLACE OF DEATH
a. COUNTY SCOTT
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SIKESTON — Inside Limits Yes ✓ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) SIKESTON — Length of stay in 1b 8 YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY SCOTT
c. CITY OR TOWN SIKESTON 1003 0 — Inside Limits Yes ✓ No ☐
d. STREET ADDRESS (If outside, give location) 215 DIXIE ST. — Reside on Farm Yes ☐ No ✓

3. NAME OF DECEASED (Type or print) First SARAH Middle HELEN Last SMITH
4. DATE OF DEATH Month 8 Day 22 Year 58
5. SEX FEMALE 3
6. COLOR OR RACE NEGRO
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5-31-15
9. AGE (In years last birthday) 43 — IF UNDER 1 YEAR Months 2 Days 21 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) CARROLTON, GA. 1
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME JOSERH HENRY EDWARDS
14. MOTHER'S MAIDEN NAME MARTHA SHEPPERD
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE
17. INFORMANT EUGENE SMITH Address SIKESTON, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dermatitis, Ulcerative,
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Sinus, c̄ Staphylococcus
DUE TO (c) Septicemia
INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 0531
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 0
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 8-11-58, to 8-22-58 and last saw her/him alive on
Death occurred at 5:20 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) A. Martin M.D. 0
22b. ADDRESS Sikeston MO
22c. DATE SIGNED 8/28/58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 8-26-58
23c. NAME OF CEMETERY OR CREMATORY SUNSET
23d. LOCATION (City, town, or county) (State) SIKESTON, MO.

24. FUNERAL DIRECTOR ADDRESS ALVIN DOTSON, SIKESTON, MO
25. DATE RECD. BY LOCAL REG. 8-30-58
26. REGISTRAR'S SIGNATURE Mrs Ella Hunter

(Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED 9-2-58
SCOTT CO. HEALTH DEPT.
CO. FILE No. 958-212

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 Iris S. Marshall

Licensed Embalmer No. 460

P. O. Address [illegible]

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.