

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

58-031994  
STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 58 Primary Registration District No. \_\_\_\_\_ Registrar's No. 452

1. PLACE OF DEATH a. COUNTY <u>CAPE Girardeau</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>CAPE GIRARDEAU</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>PORTAGEVILLE</u> <sup>0721</sup> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSPT.</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb <u>2 DAYS</u>			

3. NAME OF DECEASED (Type or print) First <u>WOLA</u> Middle <u>MAE</u> Last <u>VICKERY</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>18</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>Aug. 2, 1955</u>		9. AGE (In years last birthday) <u>3</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>LEXIE VICKERY</u>		13b. MOTHER'S MAIDEN NAME <u>ANNIE COLLINS</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. MILBURN BOYER PORTAGEVILLE 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>POLIO MYELITIS, bulbar</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		0800	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 COUNTY STATE	
21. I attended the deceased from <u>10 Aug 1958</u> <u>14 Aug</u> and last saw her/him alive on <u>14 Aug 58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>James A. Kinley MD</u>			22b. ADDRESS <u>Cape Girardeau MO</u>		22c. DATE SIGNED <u>2 Sept 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Aug. 19, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PORTAGEVILLE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PORTAGEVILLE, MO.</u>

24. FUNERAL DIRECTOR ADDRESS <u>DeLisle Funeral Parlor - Portageville Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 5, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Homer Cooper</u>	
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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

*Not Embalmed*

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.