

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011978
STATE FILE NUMBER

FILED APR 9 1959

Birth # 182 Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 51

300
1-57 0

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Benton 10-00 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hosp.		Length of stay in lb p. 1 Day	d. STREET ADDRESS (If outside, give location) Route #1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First BOBBY Middle JOE Last TODD	4. DATE OF DEATH Month 3 Day 15 Year 1959
----------------------------------------------------------------------------------------------	-------------------------------------------------------------------

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1959	9. AGE (In years last birthday) Months 1 Days 1 Hours 1 Min.
--------------------	-------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------	--------------------------------------------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sikeston, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---------------------------------------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME Wilford William Todd	13b. MOTHER'S MAIDEN NAME Marilyn Maxine Matthews	14. NAME OF HUSBAND OR WIFE _____
---------------------------------------------------	-------------------------------------------------------------	--------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT Wilford W. Todd—RFD # 1 Benton, Missouri	Address
----------------------------------------------------------------------------------------------------------------------	----------------------------------------	------------------------------------------------------------------	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral injury Traumatic labor Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Malpresentation; Cephalopelvic disproportion		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7600		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 _____ 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 BENTON, MO.	COUNTY SCOTT	STATE MISSOURI
---------------------------------------------------	------------------------------------------------------------------------------------------	----------------------------------------------------	------------------------	--------------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. CITY, TOWN, OR LOCATION BENTON, MO.	COUNTY SCOTT	STATE MISSOURI
--------------------------------------------------------------------------------------------------------	----------------------------------------------------	------------------------	--------------------------

21. I attended the deceased from 3-14-59 to 3-15-59 and last saw her alive on 2-15-59 Death occurred at 2:10 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Thomas Waltrip, MD	(By grave registration)	22b. ADDRESS Sikeston, Mo.	22c. DATE SIGNED 3-16-59
---------------------------------------------	-------------------------	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3-17-1959	23c. NAME OF CEMETERY OR CREMATORY UNITY CHURCH CEMETERY	23d. LOCATION (City, town, or county) (State) BENTON, MO.
------------------------------------------------------------	-------------------------------	--------------------------------------------------------------------	---------------------------------------------------------------------

24. FUNERAL DIRECTOR Bispinghoff Funeral Home	ADDRESS CHAFFEE, MO.	25. DATE RECD. BY LOCAL REG. 3-23-59	26. REGISTRAR'S SIGNATURE Max E. Hunter
---------------------------------------------------------	--------------------------------	------------------------------------------------	---------------------------------------------------

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 *Jack T. Burnett*
Licensed Embalmer No. *4473*

P. O. Address *Chaffee, Mo.*

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.