

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023826

STATE FILE NUMBER

FILED JUL 10 1959

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 116

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|--|------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Scott</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Scott</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Sikeston</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Agatha N. Home</u> | | Length of stay in lb <u>2 days</u> | d. STREET ADDRESS (If outside, give location) <u>201 Leelin</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Ann White</u> | | | 4. DATE OF DEATH Month Day Year <u>6-27-1959</u> |
| 5. SEX <u>7 m.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-20-1872</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawrence</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>86</u> IF UNDER 1 YEAR Months Day Hours Min. <u>7 8</u> |
| 11. BIRTHPLACE (City and state or country) <u>Warm Springs, Ark.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>John Woolidge</u> | | 13b. MOTHER'S MAIDEN NAME <u>Vivian Bailey</u> | |
| 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. <u>4260</u> | |
| 17. INFORMANT <u>Floyd Glasgow - Gray Ridge, Mo</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause of line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |
| 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 <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>6-26-59</u> to <u>6-27-59</u> and last saw her alive on <u>6-27-59</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>F.M. Larns M.D.</u> | | 22b. ADDRESS <u>Mohrhouse, Mo.</u> | |
| 22c. DATE SIGNED <u>7-3-59</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Spec) <u>Burial</u> | | 23b. DATE <u>6-30-1959</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Blountsville, Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Albritton Funeral Home</u> | | 25. DATE RECD BY LOCAL REG. <u>6-29-59</u> | |
| ADDRESS <u>Sikeston, Mo.</u> | | 26. REGISTRAR'S SIGNATURE <u>Miss Ella Hunter</u> | |

(Licensed Embalmer's Statement on Reverse Side)

Sikeston, Mo. was returned for correction

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 *Raymond L. Duffe*

Licensed Embalmer No. *4798*

P. O. Address *Dennis No.*

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.