

1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Scott</b>							
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>		Length of stay in 1b		c. CITY OR TOWN <b>Sikeston</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Comm. Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>124 6th Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JACKY</b> Middle <b>LYNN</b> Last <b>SKELTON</b>				4. DATE OF DEATH Month <b>7</b> Day <b>1</b> Year <b>1959</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1919</b>		9. AGE (last birthday) IF UNDER 1 YEAR Months <b>4</b> Days <b>2</b>		IF UNDER 24 HR Hours <b>12</b> 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) <b>Sikeston, Mo</b>			12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>JACKY SKELTON</b>				13b. MOTHER'S MAIDEN NAME <b>Shirley Lee</b>				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)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Shirley Skelton Sikeston, Mo</b> 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) <b>Hemorrhagic Dietsmia</b> 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) <b>1. Prematurity. 2. Convulsions.</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown INTERVAL BETWEEN ONSET AND DEATH <b>3da.</b>											
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 <b>12:20</b> a.m. <b>P.</b> Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>6-28-59</b> to <b>7-1-59</b> and last saw her/him alive on <b>7-1-59</b> Death occurred at <b>12:20 P.</b> m on the date stated above, and to the best of my knowledge, from the cause stated.											
22a. SIGNATURE <b>Anders B. M. M. M. M.</b> (Degree or title)						22b. ADDRESS <b>Sikeston, Mo.</b>			22c. DATE SIGNED <b>7-27-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7-2-1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greening Memorial</b>				23d. LOCATION (City, town, or county) (State) <b>Sikeston, Mo</b>			
24. GENERAL DIRECTOR <b>Shelton Funeral Home</b> <b>Sikeston, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>8-1-59</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Elliot Hunter</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**  
**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  
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.  
working under my personal supervision.

Student \_\_\_\_\_  
Student \_\_\_\_\_  
Signature of Student Embalmer \_\_\_\_\_  
Signature of Student Embalmer \_\_\_\_\_

Signed \_\_\_\_\_  
Signed \_\_\_\_\_

Licensed Embalmer No. 4798  
Licensed Embalmer No. \_\_\_\_\_  
P. O. Address \_\_\_\_\_  
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.)  
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 shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.  
If this body is not embalmed, fact should be so stated above.