

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 28 1959

'59 0 46522

STATE FILE NUMBER

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 230

ENDED

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: 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>		Length of stay in 1b	c. CITY OR TOWN <u>Sikeston</u> 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>Route 3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Elizabeth Audree</u>		4. DATE OF DEATH Month Day Year <u>12-9-1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. Marital Status Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1891</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days <u>7 26</u>	IF UNDER 24 HR Hours Min. <u>?</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>Lynn Co. Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Charles Benson</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Ellen</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Audree</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>—</u>		17. INFORMANT <u>Mary Haynes - Sikeston, Mo.</u> 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) <u>Starvation due to anoxemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral thrombosis</u>	<u>Weeks</u>
	DUE TO (c) <u>Cerebral arteriosclerosis</u>	<u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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

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. <u>—</u>	Month, Day, Year <u>—</u>		
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>April 12, 1959</u> to <u>Dec 9, 1959</u> and last saw ^{her} him alive on <u>Dec 1, 1959</u>	
Death occurred at <u>2:15</u> A m on the date stated above, and to the best of my knowledge, from the causes stated.	

22. SIGNATURE (Deceased or title) <u>Thomas Wallis - M.D.</u>		22b. ADDRESS <u>132 E. Front, Sikeston Mo.</u>	22c. DATE SIGNED <u>12-15-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-11-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Marley Cem.</u>	
23d. LOCATION (City, town, or county) (State) <u>Marley, Missouri</u>		24. FUNERAL DIRECTOR <u>Christian Funeral Home</u> <u>Sikeston, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>12-16-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Ellen Hunter</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NS DEC 28 1958

STATEMENT BY LICENSED EMBALMER

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. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Raymond L. Ruffe

Licensed Embalmer No. 4798

P. O. Address Berne, N.Y.

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.