

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004715

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTON</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MO DELTA COMM. HOSP</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u> c. CITY OR TOWN <u>SIKESTON</u> Inside Limits Yes ☒ No ☐ d. STREET ADDRESS (If outside, give location) <u>654 PARK</u> Reside on Farm Yes ☐ No ☒	
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3. NAME OF DECEASED (Type or print) First <u>WENDELL</u> Middle <u>ALLISON</u> Last <u>ANTHONY</u>			4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>60</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH <u>12-4-1893</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DENTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DENTISTRY</u>		11. BIRTHPLACE (City and state or country) <u>FREDERICKTOWN MO</u>	
13a. FATHER'S NAME <u>CARRUTHERS A. ANTHONY</u>		13b. MOTHER'S MAIDEN NAME <u>RUBY BYRD</u>		14. NAME OF HUSBAND OR WIFE <u>MARGARET E.</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW I</u>	16. SOCIAL SECURITY NO. <u>499-38-0181</u>	17. INFORMANT <u>Mrs Margaret E. Anthony - Sikeston Mo</u>
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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>ACUTE LYMPHATIC LEUKEMIA</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>approx. 4 weeks</u>
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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. ☐ Yes ☐ No ☐ Unknown	
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19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	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. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		
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 2-3-60 to 2-6-60 and last saw ~~him~~ her live on 2-6-60
 Death occurred at 10:50 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Carl G. Pops M.D.</u>	22b. ADDRESS <u>SIKESTON, MO</u>	22c. DATE SIGNED <u>2-8-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-8-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF MEMORIES</u>	23d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>
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24. FUNERAL DIRECTOR <u>Walter Funeral Home - Sikeston Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2-9-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Ella Hunter</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NS FEB 24 1960

FEB 19 1960

JAN 30 1961

MAR 23 1960

STATEMENT BY LICENSED EMBALMER

MAR 16 1960

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 Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston

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.