

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004719

FILED VS. JAN 25 1960 33

Registration District No. _____ Primary Registration District No. 3074 Registrar's No. 22 STATE FILE NUMBER

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|---|--------------------------------------|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Scott | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY New Madrid | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston | | Length of stay in lb 4 days | c. CITY OR TOWN Sikeston | | 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. Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Route 3 | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle VERNON Last BRITT | | | 4. DATE OF DEATH Month 1 Day 9 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12-19-98 | 9. AGE (last birthday) 61 | IF UNDER 1 YEAR IF UNDER 24 HR Months 0 Days 23 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Salvage Yard | 11. BIRTHPLACE (City and state or country) Illinois | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME No Record | | 13b. MOTHER'S MAIDEN NAME No Record | | 14. NAME OF HUSBAND OR WIFE Helen Davis Britt | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Navy Dates DK | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address R#3 Mrs. Helen D. Britt, Sikeston, Mo. | | | |

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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) 2° + 3° burns of head, neck, back, both arms, feet | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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) | | | | 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 SUICIDE HOMICIDE XX <input type="checkbox"/> <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Burns received when fire destroyed home. | | | |
| 20c. TIME OF INJURY Hour 1:30 a.m. 1-5-60 | | | | | |
| 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.) At Home | 20f. CITY, TOWN, OR LOCATION Route #3, Sikeston, Mo. | | COUNTY STATE | |
| 21. I attended the deceased from 1-5-60 to 1-9-60 and last saw ^{her} him alive on 8:30 A . Death occurred at 8:30 A on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Wm. C. Cretchlow MD | | | 22b. ADDRESS Sikeston, Mo. | | 22c. DATE SIGNED 1-10-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1-11-60 | 23c. NAME OF CEMETERY OR CREMATORY Garden Of Memories | | 23d. LOCATION (City, town, or county) (State) Sikeston, Missouri | |
| 24. FUNERAL DIRECTOR Edw. E. Krumholz Fun. Chapel, Sikeston, Mo. | | 25. DATE RECD. BY LOCAL REG. 1-16-60 | 26. REGISTRAR'S SIGNATURE Wm. Ella Hunter | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Edward E. Funnell

Licensed Embalmer No. 4164

P. O. Address Sibolga

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.