

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022004

FILED VS MAY 27 1960

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 129

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| 1. PLACE OF DEATH a. COUNTY <u>Scott</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</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>Morehouse</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MO DELTA Comm. Hospital</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Clementine Lewis</u> | | | 4. DATE OF DEATH Month Day Year <u>May 11 1960</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Caucasian</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>8-3-90</u> | 9. AGE (last birthday) <u>69</u> | # UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 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>housewife</u> | 11. BIRTHPLACE (City and state or country) <u>Galatia, Ill.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>James M. DeGroat</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary M. Martin</u> | | 14. NAME OF HUSBAND OR WIFE <u>deceased</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u> | | 17. INFORMANT Address <u>Lorraine Grimes 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>Toxemia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> |
| DUE TO (b) <u>Thrombosis left external iliac artery</u> | | <u>36 hrs</u> |
| DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary emphysema</u> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. Month, Day, Year | | |

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| 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>1-30-60</u> to <u>5-11-60</u> and last saw her <u>alive</u> on <u>5-11-60</u> Death occurred at <u>8:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | |

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| 22a. SIGNATURE (Degree or title) <u>John D. Sargent MD</u> | 22b. ADDRESS <u>707 Tanner Street Sikeston, Missouri</u> | 22c. DATE SIGNED <u>5-11-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>5-13-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u> |
| 23d. LOCATION (City, town, or county) (State) <u>Sikeston, Mo.</u> | | |

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| 24. FUNERAL DIRECTOR ADDRESS <u>Watkins & Sons Morehouse, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>5-16-60</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs Ella Hunter</u> |
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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 Marsh Watkins

Licensed Embalmer No. 4717

P. O. Address Dexter

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.