

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH **211** -60-033493

FILED VS SEP 8 1960 **333** Primary Registration District No. **3074** Registrar's No. **3074** 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 Mo b. COUNTY scott | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston | | Length of stay in 1b 10MRS. | c. CITY OR TOWN SIKESTON Inside Limits Yes <input checked="" type="checkbox"/> No <input 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) 408 TANNER Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First CLARA Middle EDITH Last MATTHEWS | 4. DATE OF DEATH Month 8 Day 27 Year 1960 |
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| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11-2-1892 | 9. AGE (last birthday) 67 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | 11. BIRTHPLACE (City and state or country) DAVIES Co. FND. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME JESSE FLOYD COX | 13b. MOTHER'S MAIDEN NAME JULIA TOMMY | 14. NAME OF HUSBAND OR WIFE GLENN A. |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. - | 17. INFORMANT Gleann A. Matthews Sr. Sikeston Mo Address |
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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) cardiac insufficiency | | 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) _____ | | |

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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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 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 checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION Sikeston | COUNTY Mo | STATE |
|---|--|---|---------------------|-------|

21. I attended the deceased from **Jan 25, 1958** to **Aug 27, 1960** and last saw her/him alive on **Aug 27, 1960**
Death occurred at **10:00 P.** 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) Wm. C. Critchlow M.D. | 22b. ADDRESS Sikeston, Mo. | 22c. DATE SIGNED 8-29-60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 8-29-60 | 23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK | 23d. LOCATION (City, town, or county) (State) SIKESTON Mo |
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| 24. FUNERAL DIRECTOR Welch Funeral Home - Sikeston Mo ADDRESS | 25. DATE RECD. BY LOCAL REG. 9-1-60 | 26. REGISTRAR'S SIGNATURE Miss Ella Hunter |
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

.NS JUN 1 2 1964

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 Crews

Licensed Embalmer No. 346

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.