URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

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NDED

Registration District No. _____ Primary Registration District No. 3074 Registrar's No. 27E

60-044824
STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY: SCOTT
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: SIKESTON
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 108A W. CENTER ST
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO
b. COUNTY: SCOTT
c. CITY OR TOWN: SIKESTON
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 108A W. CENTER ST
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: CHARLES Middle: LACY Last: MASON
4. DATE OF DEATH: Month 11 Day 8 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10-28-1915
9. AGE (last birthday): 45
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HR: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COOK
10b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT
11. BIRTHPLACE (City and state or country): CAIRO ILL
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: CHARLES E.
13b. MOTHER'S MAIDEN NAME: —
14. NAME OF HUSBAND OR WIFE: WILMA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 565-20-2231
17. INFORMANT: Max C.L. Mason Address: Sikeston Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
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. ☐ Yes ☐ No ☐ Unknown

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. Month, Day, Year
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 1957, to 11-8-60 and last saw her/him alive on D.O.A.
Death occurred at about 4 P.M. 11/8/60 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: E. D. Urban (Degree or title) M.D.
22b. ADDRESS: Sikeston
22c. DATE SIGNED: 11-9-60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10-10-60
23c. NAME OF CEMETERY OR CREMATORY: SMITH-GRIGGS
23d. LOCATION (City, town, or county) (State): MISS Co. Mo

24. FUNERAL DIRECTOR: Welch Funeral Home ADDRESS: Sikeston Mo
25. DATE RECD. BY LOCAL REG.: 11-11-60
26. REGISTRAR'S SIGNATURE: Mrs Ella Hunter

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MAR 14 1961

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_____ Signed Raymond Crews

Signature of Student Embalmer

Licensed Embalmer No. 3467

P. O. Address Lakeland

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