

FILED VS DEC 19 1960

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-048442

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 287

|  |                                  |   |   |   |   |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Scott</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Scott</b> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN<br><b>Sikeston</b>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN<br><b>Sikeston</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>Home</b>  |                                  | Length of stay in 1b  | d. STREET ADDRESS<br>(If outside, give location)<br><b>Helen St.</b>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Mrs. Mattie Bob Tyrone</b>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>12-1-1960</b>  |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 12 1887</b>   |   | 9. AGE (In years last birthday)<br><b>73</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>DeSoto County Miss.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?  |
| 13a. FATHER'S NAME<br><b>Burd Abernathy</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Nannie Hughey</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>J.L. Tyrone</b> |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br>Address<br><b>J.L. Tyrone Sikeston Mo.</b>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of tongue</b>  |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Approx 5 yrs</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <b>141.9</b>  |                                  |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |                                  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>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.)  |   |   |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |                                  |   |   |   |   |
| 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 <b>11-29-60</b> to <b>12-1-60</b> and last saw <sup>her</sup> alive on <b>11-29-60</b><br>Death occurred at <b>7:40</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>John Sargent MD</b>   |                                  |   | 22b. ADDRESS<br><b>707 Tanager Sikeston Missouri</b>  |   | 22c. DATE SIGNED<br><b>12-6-60</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |                                  | 23b. DATE<br><b>12-4-60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maple</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Caruthersville Mo.</b>                        |
| 24. FUNERAL DIRECTOR<br><b>Cobb Funeral Home</b>   |                                  | ADDRESS<br><b>Blytheville</b>   | 25. DATE RECD. BY LOCAL REG.<br><b>12-6-60</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Ella Hunter</b>  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 192.140 MoRS 1949.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *J. B. [Signature]* .....

Licensed Embalmer No. 3100 .....

P. O. Address.....Blytheville..Ark

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.