

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH 64

-61-016134

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 6115 Registrar's No. 64

AMENDED

FILED MAY 4 1961

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		Length of stay in-lb <u>13 Yrs.</u>	c. CITY OR TOWN <u>Sikeston</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>Route 1, Box 6</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 1, Box 6</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ester</u> Middle <u>Mills</u> Last <u>Mills</u>			4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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>9-21-1900</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>24</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
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>-</u>		11. BIRTHPLACE (City and state or country) <u>Slaysprings, Miss.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Jim Eanes</u>		13b. MOTHER'S MAIDEN NAME <u>-</u>		14. NAME OF HUSBAND OR WIFE <u>Jim Mills</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>		17. INFORMANT Address <u>Jim Mills, 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>Carcinoma of breast with</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>multiple metastases</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 mo?</u>
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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.)	
20c. TIME OF INJURY Hour <u>-</u> Month, Day, Year <u>-</u>		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 COUNTY STATE	

21. I attended the deceased from 4/24/59 to 4/14/61 and last saw her alive on 3/25/61
Death occurred at 3:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Wm. C. Cutchlow M.D.</u>		22b. ADDRESS <u>Sikeston, Mo.</u>		22c. DATE SIGNED <u>April 20, 1961</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-16-61</u>	23b. DATE <u>4-16-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset of Memory</u>	23d. LOCATION (City, town, or county) (State) <u>Sikeston Mo.</u>	

24. FUNERAL DIRECTOR ADDRESS <u>Alvin Dotson, Sikeston, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-24-61</u>	26. REGISTRAR'S SIGNATURE <u>Miss Ella Hunter</u>
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STATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 *Tris S. Manshori*

Licensed Embalmer No. 4601

P. O. Address *Superston*

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.