

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-034734

AMENDED

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

ITEM NO.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9034 STATE FILE NUMBER

FILED OCT 13 1961

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</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>ST. LOUIS</u>		c. CITY OR TOWN <u>Sikeston</u>	
Length of stay in lb <u>6 wks</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JEWISH HOSP. OF ST. LOUIS</u>		d. STREET ADDRESS (If outside, give location) <u>111 WEST GATE</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>LIZZIE</u> Middle <u>-</u> Last <u>NELSON</u>			4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>'61</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</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>2/14/89</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></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		11. BIRTHPLACE (City and state or country) <u>MISSISSIPPI</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Calvin Mitchell</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Clark</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</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 <u>Annie Williams</u>		Address <u>111 West Gate, 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:			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>			
DUE TO (b) <u>CARCINOMA OF BREAST</u>			
DUE TO (c) <u>GEN'L ARTERIOSCLEROSIS - AMPUTATION @ Leg</u>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>170+</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 checked="" 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.) <u>...</u>	
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20c. TIME OF INJURY Hour <u></u> Minute <u></u> p.m. <u></u>	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
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21. I attended the deceased from 8-19-1961 to 10-1-1961 and last saw her/him alive on 10-1-1961
Death occurred at 1:45 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Kay J. Wolff, M.D.</u>	(Degree or title)	22b. ADDRESS <u>216 S. Kingshighway</u>	22c. DATE SIGNED <u>10-1-61</u>
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23a. BURIAL CREMATION REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/2/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Garden Of Memories Sikeston Mo</u>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <u>Dotson Funeral Home, Sikeston Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>OCT 2 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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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 PL. - Patsor

Licensed Embalmer No. Patsor

P. O. Address _____

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.