MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-001431
STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 23

AMENDED

FILED JAN 29 1962

1. PLACE OF DEATH
a. COUNTY: Howell
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: West Plains
Length of stay in 1b: 6 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: West Plains Memorial Hosp. Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Arkansas b. COUNTY: Fulton
c. CITY OR TOWN: Camp Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Nancy Middle: Last: Sickler
4. DATE OF DEATH Month: Jan. Day: 25 Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-28-1895
9. AGE (last birthday): 66
IF UNDER 1 YEAR / IF UNDER 24 HR: Months / Days / Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafe Cook
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Norfork, Virginia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: George Wright
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Thurlow Sickler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

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) Acute Pulmonary Edema
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cardiomegaly with decompensation
DUE TO (c) Pneumonia, Rt
INTERVAL BETWEEN ONSET AND DEATH
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 20/1/62, to and last saw her alive on 25/1/62
Death occurred at 0900 hrs m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) MD
22b. ADDRESS West Plains Mo
22c. DATE SIGNED 26/1/62

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Hammond, Indiana

24. FUNERAL DIRECTOR ADDRESS: Carter Funeral Home, West Plains, Mo.
25. DATE RECD. BY LOCAL REG.: 1-26-62
26. REGISTRAR'S SIGNATURE: Beatrice Cook

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED	BY AFFIDAVIT OF
				DOCUMENT

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 Leland Carter

Licensed Embalmer No. 4516

P. O. Address West Plains, Mo

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.