

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -62-018267

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 253

STATE FILE NUMBER

FILED JUN 11 1962

VS 300
Rev. 4/59

1 0168
2 10072
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4 3
5 2
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7 1
8 2
9 2040
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12 2-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Cape		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.		b. COUNTY Scott	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau, Mo.		Length of stay in 1b 2 Weeks		c. CITY OR TOWN Sikeston	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Frances Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		-d. STREET ADDRESS (If outside, give location) 207 Westgate St.	
3. NAME OF DECEASED (Type or print) First Middle Last Emma Anderson			4. DATE OF DEATH Month Day Year 6 5 1962		
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/3/1890	9. AGE (last birthday) 72	10. IF UNDER 1 YEAR Months Days 3 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) Fort Piller, Miss.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME —		13b. MOTHER'S MAIDEN NAME —		14. NAME OF HUSBAND OR WIFE —	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Ollie Fair, Sikeston, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic lymphocytic leukemia</i>					INTERVAL BETWEEN ONSET AND DEATH 2 mo
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 Month, Day, Year 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 <i>May 20, 1962</i> to <i>June 5, 1962</i> and last saw her/him alive on <i>6-5-62</i> Death occurred at <i>2:30 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Alvin Dotson, M.D.</i>			22b. ADDRESS <i>837 Broadway, Cape Girardeau, Mo.</i>		22c. DATE SIGNED <i>6-8-62</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 6/10/1962	23c. NAME OF CEMETERY OR CREMATORY Sunset of Memory		23d. LOCATION (City, town, or county) Sikeston, Mo.	(State)
24. FUNERAL DIRECTOR Alvin Dotson, Sikeston, Mo.		DATE RECD. BY LOCAL REG. <i>June 9-1962</i>		26. REGISTRAR'S SIGNATURE <i>Alvin Dotson</i>	

USE BLACK INK OR TYPEWRITER RIBBON

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 *Chris S. Marshall*

Licensed Embalmer No. 4601

P. O. Address *Suburban Md*

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.