

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-014593

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 82

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED MAR 29 1963**

VS 300  
Rev. 4/59

1007  
2007  
3  
4 1  
5 3  
6  
7 0  
8 0  
94201  
10  
11  
12 1-0  
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>SCOTT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>SCOTT</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SIKESTON</b>		Length of stay in 1b <b>4 days</b>		c. CITY OR TOWN <b>SIKESTON</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MO. DELTA COMMUNITY HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>948 LAKE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY HAVILLA TRIGG</b>			4. DATE OF DEATH Month Day Year <b>3-23-63</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <b>4-29-1916</b>		9. AGE (last birthday) <b>46</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>NEW MADRID MO</b>	
12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		13a. FATHER'S NAME <b>ARTHUR TRIGG</b>		13b. MOTHER'S MAIDEN NAME <b>MARY OZEL HATHCOTE</b>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of <b>No</b> )		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Arthur Trigg - Sikeston Mo</b>		18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): <b>atrial fibrillation</b>				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 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>3/19/63</b> to <b>3-23-63</b> and last saw her <del>her</del> <b>alive</b> on <b>3-23-63</b> Death occurred at <b>11:40 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Wm. C. Critchlow M.D.</b>				22b. ADDRESS <b>Sikeston</b>	
22c. DATE SIGNED <b>3/25/63</b>				22d. LOCATION (City, town, or county) <b>SIKESTON MO</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3-25-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDEN OF MEMORIES</b>	
24. FUNERAL DIRECTOR <b>Welch Funeral Home - Sikeston Mo</b>		25. DATE RECD. BY LOCAL REG. <b>March 27 - 1963</b>		26. REGISTRAR'S SIGNATURE <b>Jeanette Waldman</b>	

USE BLACK INK OR TYPEWRITER RIBBON

no permit

**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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address St. Louis 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.