

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40387

State File No.

FILED DEC 14 1951

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 185

1. PLACE OF DEATH a. COUNTY <u>SCOTT 1003</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, write RURAL and give township) <u>SIKESTON</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>SIKESTON 1003</u>	
c. LENGTH OF STAY (In this place) <u>10yr</u>		d. STREET ADDRESS (If rural, give location) <u>707 MOORE 0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>707 MOORE</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>NORA</u>	b. (Middle) <u>BURTON</u>	c. (Last) <u>McGINNIS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 3, 1951</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>JAN 12 1870</u>	9. AGE (In years last birthday) <u>81</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>GA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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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 (State or foreign country) <u>GA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>SAMUEL HOWARD</u>	13b. MOTHER'S MAIDEN NAME <u>AMANDA JONES</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lehaa Butler, Sikeston Mo</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Influenza</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 11-26, 1951, to 12-3, 1951, that I last saw the deceased alive on 12-1, 1951, and that death occurred at 6 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>C. Hunter M.D.</u> (Degree or title)	23b. ADDRESS <u>Sikeston Mo</u>	23c. DATE SIGNED <u>12-4-51</u>
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24a. BURIAL/CREMATION REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>12/7/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MYRTLE</u>	24d. LOCATION (City, town, or county) (State) <u>MYRTLE MO</u>
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DATE REC'D BY LOCAL REG. <u>12-7-51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Ollas Hunter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Welsh Funeral Home - Sikeston Mo</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED DEC 10 195

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 1251-2

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 _____
Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sebastian 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 this body is not embalmed, fact should be so stated above.