

FILED APR 19 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15297

BIRTH NO. 27086 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 74

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sikeston, Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Bell City</u>	
c. LENGTH OF STAY (In this place) <u>2 days</u>		d. STREET ADDRESS (If rural, give location) <u>Rt#1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Branda</u>	b. (Middle) <u>—</u>	c. (Last) <u>Wingfield</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3 30 1952</u>
--	-----------------------------	-------------------------	-------------------------------	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3-28-1952</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>—</u>	IF UNDER 1 YEAR Days <u>2</u>	IF UNDER 1 HR. Hours <u>—</u>	IF UNDER 1 HR. Mins. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Sikeston, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		

13a. FATHER'S NAME <u>Clarence Wingfield</u>	13b. MOTHER'S MAIDEN NAME <u>Muriel Kirby</u>	14. NAME OF HUSBAND OR WIFE <u>—</u>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Clarence Wingfield</u>	ADDRESS <u>Bell City Rt#1</u>
--	--	-------------------------------------	--	----------------------------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atelectasis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>—</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>7620</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	---	---

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)
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?

22. I hereby certify that I attended the deceased from 3-28, 1952, to 3-30, 1952, that I last saw the deceased alive on 3-30, 1952, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>E. D. Urban</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Sikeston, Mo.</u>	23c. DATE SIGNED <u>3-31-52</u>
--------------------------------------	----------------------------------	--------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>3-31-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City</u>	24d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>
--	-----------------------------	---	---

DATE REC'D BY LOCAL REG. <u>4-10-52</u>	REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Welch Funeral Home - Sikeston Mo</u>	ADDRESS
--	--	---	---------

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1003

RECEIVED APR 14 1952

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 452-108

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Raymond Crews

Signed.....
Student Embalmer

Licensed Embalmer No. 2467

P. O. Address Sikeston 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.