

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19046

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 110

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SIKESTON</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SIKESTON</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MO. DELTA COMM. HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>RT # 1</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ELZIE</u>	b. (Middle) <u>BURTON</u>	c. (Last) <u>NELSON</u>	4. DATE OF DEATH: (Month) (Day) (Year) <u>MAY 30, 1952</u>
--	-------------------------	---------------------------	-------------------------	---

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6-16-1898</u>	9. AGE (In years last birthday) <u>53</u>	if UNDER 1 YEAR Months Days	if UNDER 1 MIN. Hours
--------------------	-------------------------------	---	-----------------------------------	---	-----------------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>C.D. MATTHEWS EST.</u>	11. BIRTHPLACE (State or foreign country) <u>ARKANSAS</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	---	---	--

13a. FATHER'S NAME <u>JOHN NELSON</u>	13b. MOTHER'S MAIDEN NAME <u>MAGGIE MARION</u>	14. NAME OF HUSBAND OR WIFE <u>GEORGIA ?</u>
---------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>---</u>	16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Georgia Nelson Sikeston R 1</u>	ADDRESS
--	------------------------------------	--	---------

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>Coronary Infarction</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4201</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) (Minute)	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 5-22, 1952, to 5-30, 1952, that I last saw the deceased alive on 5-30, 1952, and that death occurred at 7:45 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Alfred Hargent MD</u>	23b. ADDRESS <u>Sikeston Mo</u>	23c. DATE SIGNED <u>5-30-52</u>
---	---------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/2/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Sikeston Mo</u>
---	-------------------------	---	--

DATE REC'D BY LOCAL REG. <u>6-7-52</u>	REGISTRAR'S SIGNATURE <u>Mrs. Clara Hunter</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Clara Hunter</u>	ADDRESS
--	--	--	---------

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

FILED JUN 13 1952

RECEIVED 6-9-52
SCOTT COUNTY HEALTH CENTER
CO. FILE NO. 652-169

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.....

John Allerton

Signed.....
Student Embalmer

Licensed Embalmer No. 2941

P. O. Address Keosauqua 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.