

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27630

State File No. ....

FILED

SEP 9 - 1952 52880

REG. DIST. NO. 104

PRIMARY REG. DIST. NO. 4176

Registrar's No. 38

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

1. PLACE OF DEATH a. COUNTY <b>Dunklin</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Malden</b>		c. LENGTH OF STAY (In this place) <b>6 Days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>4 Miles West Parma 0720</b>		d. STREET ADDRESS (If rural, give location) <b>Above</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bailey Hospital</b>							
3. NAME OF DECEASED (Type or Print) a. (First) <b>Vernitta</b> b. (Middle) <b>Kay</b> c. (Last) <b>Sheckell</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>August 18 1952</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Infant</b>		8. DATE OF BIRTH <b>August 4-1952</b>	
9. AGE (In years last birthday) <b>0</b>		10. MONTHS <b>0</b>		11. DAYS <b>14</b>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Clyde Raymond Sheckell</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Lucille Sheckell</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mary Sheckell</b>			
		16. SOCIAL SECURITY NO. <b>None</b>		17. ADDRESS <b>Route 2 Parma</b>			
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.							
<b>MEDICAL CERTIFICATION</b>							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>acute dysentery</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
ANTECEDENT CAUSES Morbidity 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.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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 <b>8/17</b> , 1952, to <b>8/17</b> , 1952, that I last saw the deceased alive on <b>8/17</b> , 1952, and that death occurred at <b>9:20 AM.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>J. Bailey Ohnd</b>				23b. ADDRESS <b>Malden, Mo</b>		23c. DATE SIGNED <b>8/18/52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>8/19/52</b>		24c. NAME OF CEMETERY OR CREMATORY <b>MALDEN</b>		24d. LOCATION (City, town, or county) (State) <b>MO.</b>	
DATE REC'D BY LOCAL REG. <b>8/27/52</b>		REGISTRAR'S SIGNATURE <b>J. S. Scholman</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>DAY FUNERAL HOME</b>			
				ADDRESS <b>MALDEN, MO.</b>			

RECEIVED DUNKLIN COUNTY HEALTH

DEPARTMENT 9-2-52

COUNTY FILE NUMBER 952-234

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**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 \_\_\_\_\_

NOT EMBALMED

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.