

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41254**

BIRTH NO. **74011** REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. **221**

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Scott	
b. CITY OR TOWN Sikeston		c. CITY OR TOWN Sikeston 1000	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Community Hosp.		d. STREET ADDRESS (If rural, give location) Route 1	

3. NAME OF DECEASED (Type or Print)	a. (First) Brenda	b. (Middle) Janice	c. (Last) Stone	4. DATE OF DEATH (Month) (Day) (Year) 11-10-1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Baby	8. DATE OF BIRTH 11-29-1952	9. AGE (In years last birthday) — MONTHS — DAYS 12 HOURS 8 MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby	10b. KIND OF BUSINESS OR INDUSTRY Baby	11. BIRTHPLACE (State or foreign country) Sikeston, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James Stone	13b. MOTHER'S MAIDEN NAME Bernice Rebelle	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME James Stone R#1 Sikeston, Mo	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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		INTERVAL BETWEEN ONSET AND DEATH 12 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. 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 776X	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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10/29**, 19**52**, to **11/10**, 19**52**; that I last saw the deceased alive on **11/10**, 19**52**, and that death occurred at **3 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm. C. Pritchard M.D.	23b. ADDRESS Sikeston, Mo	23c. DATE SIGNED Nov. 12, 1952
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/12/52	24c. NAME OF CEMETERY OR CREMATORY Carpner Cem	24d. LOCATION (City, town, or county) (State) R#1 Sikeston, Mo
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DATE REC'D BY LOCAL RES. 11-25-52	REGISTRAR'S SIGNATURE Mrs. Ella Hunter	GENERAL DIRECTOR'S SIGNATURE Henry Jones	ADDRESS Sikeston, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

10030

RECEIVED

DEC 1 1952

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 1252-326

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 Alutto

Signed.....

Student Embalmer

Licensed Embalmer No. 3941

P. O. Address *Keaton*

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.