

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

8423

State File No. ....

40

Registrar's No. ....

BIRTH NO. 12935 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before death.)	
a. COUNTY <u>Scott</u>	a. STATE <u>Missouri</u>		b. COUNTY <u>New Madrid</u>
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>	c. LENGTH OF STAY (in this place) <u>12 hrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lilbourn</u> <u>0720</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hosp.</u>		d. STREET ADDRESS (If rural, give location) <u>Route 1</u>	

<b>3. NAME OF DECEASED</b> (Type or Print)	a. (First) <u>Patsy</u>	b. (Middle) <u>Ann</u>	c. (Last) <u>Wright</u>	<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>2-20-1953</u>
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<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Baby</u>	<b>8. DATE OF BIRTH</b> <u>2-19-1953</u>	<b>9. AGE</b> (In years last birthday) <u>—</u> <b>IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u> <b>IF UNDER 12 HRS.</b> Hours <u>12</u> Min. <u>—</u>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Baby</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baby</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Sikeston, Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
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<b>13a. FATHER'S NAME</b> <u>Marion Morris Wright</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mildred Marie Rankin</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>—</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b> <u>—</u>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Marion Morris Wright, Lilbourn, Mo</u>	<b>ADDRESS</b> <u>Lilbourn, Mo</u>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 day</u>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Atelectasis</u>		
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
	<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <u>Prematurity</u>		<u>1 day</u>

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <u>7625</u>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to 2/20, 1953, that I last saw the deceased alive on 2/20, 1953, and that death occurred at 7:45 m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <u>Wm. C. Citchlow M.D.</u>	(Degree or title)	<b>23b. ADDRESS</b> <u>Sikeston, Mo</u>	<b>23c. DATE SIGNED</b> <u>Feb 29, 1953</u>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>24b. DATE</b> <u>2-21-53</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>MOUNDS</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>NEW MADRID MO</u>
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<b>DATE REC'D BY LOCAL REG.</b> <u>3-6-53</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. Ella Hunter</u>	<b>429</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Marion Morris Wright</u>	<b>ADDRESS</b> <u>FAMILY Burial</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

3. No. 300  
V. 10. 48

FILED MAR 13 1953

1003

RECEIVED

MAR 9 1953

SCOTT COUNTY HEALTH CENTER

CO. FILE NO.

353-64

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.....

Signed.....  
Student Embalmer

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.