

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24425**
5904

BIRTH MO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Scott	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 1003	

3. NAME OF DECEASED (Type or Print)	a. (First) Ann	b. (Middle) Elizabeth	c. (Last) Dace	4. DATE OF DEATH (Month) (Day) (Year) June 26, 1954
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 11-19-1914	9. AGE (In years last birthday) 39	# UNDER 1 YEAR	# UNDER 1 Mth.
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10a. USUAL OCCUPATION (Give kind of work during life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME A. R. Childress	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Melvin Dace
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Melvin Dace, Sikeston, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of liver				hrs.
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
		Morbid 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 checked="" type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 5810
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22. I hereby certify that I attended the deceased from **May 20, 1954**, to **June 26, 1954**, that I last saw the deceased alive on **June 26, 1954**, and that death occurred at **7:10A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Carl Smith, M.D.	(Degree or title)	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 6/26/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-28-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Sikeston, Mo.
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DATE REC'D BY LOCAL REG. JUN 30 1954	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albritton F.H., Sikeston, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2021-3-10P

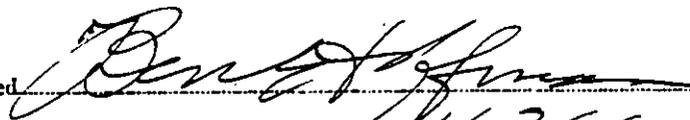
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed 

Licensed Embalmer No. 14366

P. O. Address 20 Jones St

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.