

FILED SEP 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **32769**

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 136	
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 (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston		c. LENGTH OF STAY (in this place) 1 Day		c. CITY OR TOWN Sikeston		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Community Hospital				e. STREET ADDRESS (If rural, give location) 223 Northwest St. 10030			
3. NAME OF DECEASED (Type or Print) a. (First) Ruth b. (Middle) Warren c. (Last) Deloach			4. DATE OF DEATH (Month) (Day) (Year) 9 13 1954				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 8-19-1899	
9. AGE (In years last birthday) 55		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY 0		11. BIRTHPLACE (City and State or Foreign Country) Sikeston, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Thomas Warren, Decd.			13b. MOTHER'S MAIDEN NAME Oliver Farmer		14. NAME OF HUSBAND OR WIFE A. D. Deloach		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 0		17. INFORMANT'S SIGNATURE OR NAME Mrs. Jewell Willer, Cape Girardeau, Mo.		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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema ANTECEDENT CAUSES Coronary Thrombosis 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. Ess. Hypertension					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 4201				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 9-12, 1954 , to 9-13, 1954 , that I last saw the deceased alive on 9-13, 1954 , and that death occurred at 9:35A. m. , from the causes and on the date stated above.							
23a. SIGNATURE E. D. Urban M.D. (Degree or title)				23b. ADDRESS Sikeston		23c. DATE SIGNED 9-24-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/15/54		24c. NAME OF CEMETERY OR CREMATORY Lorimer Cemetery		24d. LOCATION (City, town, or county) (State) Cape Girardeau, Mo	
DATE REC'D BY LOCAL REG. 9-15-54		REGISTRAR'S SIGNATURE Mrs. Cella Hunter		25. FUNERAL DIRECTOR'S SIGNATURE Albritton		ADDRESS Funeral Home Sikeston, Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

10030

DATE RECEIVED

SEP 20 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No.

954-19B

SEP 20 1954

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.....
Signature of Student Embalmer

Signed *John Allerton*

Licensed Embalmer No. 29

P. O. Address *Spokane*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.