

No. 300
10.48

FILED NOV 12 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36208

State File No.

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 157

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). 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. CITY OR TOWN <u>Matthews</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>D.O.A.</u>		e. STREET ADDRESS (If rural, give location) <u>-----</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Delta Comm. Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Alica</u> b. (Middle) <u>-----</u> c. (Last) <u>Fuentes</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10-28-1954</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Mexican</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>10-11-1954</u>	9. AGE (In years last birthday) <u>-</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Dell, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>Joe Fuentes</u>	13b. MOTHER'S MAIDEN NAME <u>Alica Fuentes</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
---------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, specify unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>0</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Father, Joe Fuentes, Matthews, Mo.</u>	ADDRESS <u>-----</u>
---	----------------------------------	---	----------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>-----</u>		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>few hours.</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Probable pneumonia</u>		DUE TO (b) <u>Upper respiratory infection</u>		<u>3 days.</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>-----</u>		
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 <u>7630</u>	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) m.	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 first call after death, 19, that I last saw the deceased alive on 10-28, 1954, and that death occurred at 3:30 A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Thelma C. Burdthorpe - M.D. Health Officer</u>	23b. ADDRESS <u>Benton, Mo</u>	23c. DATE SIGNED <u>10-29-54</u>
--	--------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10/28/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Harold's Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>New Madrid, Mo.</u>
---	---------------------------	---	--

DATE REC'D BY LOCAL REG. <u>11-1-54</u>	REGISTRAR'S SIGNATURE <u>Mrs. Ella Fuentes</u> 429	25. FUNERAL DIRECTOR'S SIGNATURE <u>Welch Funeral Home, Sikeston, Mo.</u>	ADDRESS <u>-----</u>
---	--	---	----------------------

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

1603
33

DATE RECEIVED

NOV 8 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No.

154-225

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..... *Raymond Cress*

Licensed Embalmer No. 346

P. O. Address *Lester*

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.