

FILED JAN 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43353**

BIRTH NO. _____ REG. DIST. NO. 217 PRIMARY REG. DIST. NO. 3045 Registrar's No. 11

1. PLACE OF DEATH
a. COUNTY Mississippi
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Charleston
c. LENGTH OF STAY (in this place) 15 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION 603 Green St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Miss.
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Charleston 0672
d. STREET ADDRESS (If rural, give location) 603 Green St. 0

3. NAME OF DECEASED (Type or Print)
a. (First) Flora b. (Middle) _____ c. (Last) Govand
4. DATE OF DEATH (Month) (Day) (Year) Oct. 11, 1954

5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH July 14, 1903 9. AGE (In years last birthday) 51 IF UNDER 1 YEAR Months 2 Days 27 IF UNDER 24 HRS. 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 _____ 11. BIRTHPLACE (State or foreign country) Holly Grove, Ark. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Cokly Richardson 13b. MOTHER'S MAIDEN NAME Mary Davis 14. NAME OF HUSBAND OR WIFE Gentle Govand

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Gentle Govand ADDRESS 603 Green, Charleston, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident INTERVAL BETWEEN ONSET AND DEATH 2 months
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension
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 NO 331X

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 2-27, 1952, to 10-11, 1954, that I last saw the deceased alive on 10-10, 1954, and that death occurred at 8:45A.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature] 23b. ADDRESS Charleston, Mo. 23c. DATE SIGNED 10/16/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Oct. 17, 1954 24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery 24d. LOCATION (City, town, or county) (State) Charleston, Missouri

DATE REC'D BY LOCAL REG. 12-28-54 REGISTRAR'S SIGNATURE 490 Jean Deasmes 25. FUNERAL DIRECTOR'S SIGNATURE F. J. Sparks ADDRESS Charleston, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

672

JAN 21 REC'D

RECEIVED

Miss. Co. Health Dept

County File No. JAN 22 1955

Date Filed JAN 22 1955

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 Frank Sparks

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau Mo

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.