

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14397

State File No.

FILED MAY 9 1955

BIRTH NO. _____ REG. DIST. NO. 222 PRIMARY REG. DIST. NO. 2074 Registrar's No. 55

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>	
b. CITY OR TOWN <u>Sikeston</u>		c. CITY OR TOWN <u>Parma</u>	
c. LENGTH OF STAY (in this place township) <u>3 days</u>		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 <u>Delta Community Sikeston</u>		e. STREET ADDRESS (If rural, give location) _____	

0729

3. NAME OF DECEASED a. (First) <u>William</u> b. (Middle) <u>Henry</u> c. (Last) <u>Floyd</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 17, 1955</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec 18, 1883</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired shop operator</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Cape County Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>Henry Floyd</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>deceased</u>
---------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Milford Floyd, Robbs, Illinois</u>	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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2-4 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Probable Coronary Thrombosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Rectal hemorrhage</u> 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 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) _____	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 4-14, 1955, to 4-17, 1955, that I last saw the deceased alive on 4-17, 1955, and that death occurred at 2:00 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>E. D. Urban M.D.</u> (Degree or title)	23b. ADDRESS <u>Sikeston, Mo.</u>	23c. DATE SIGNED <u>4-22-55</u>
--	-----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>Apr. 19 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Dexter Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Dexter Missouri</u>
---	-------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>4-26-55</u>	REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Watkins Funeral Service</u>	ADDRESS <u>Parma, MO.</u>
---	---	---	---------------------------

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

DATE RECEIVED MAY 2 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 55-91

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 Mark W. Atkins

Licensed Embalmer No. 4715

P. O. Address Scott Co. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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