

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20796

FILED JUL 8 - 1955

State File No. 82

BIRTH NO. _____		REG. DIST. NO. <u>339</u>		PRIMARY REG. DIST. NO. <u>2074</u>		Registrar's No. <u>82</u>					
1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Scott</u>							
b. CITY (If outside corporate limits, write RURAL and give town) <u>Sikeston</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Sikeston</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>118 N. HANDY</u>				STREET ADDRESS (If rural, give location) <u>118 N- HANDY 1003</u>							
3. NAME OF DECEASED a. (First) <u>MAUDE</u>		b. (Middle) <u>STARLING</u>		c. (Last) <u>DIVINNY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6-25-55</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>3-23-1897</u>					
9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months <u>3</u>		IF UNDER 1 YEAR Days <u>2</u>		IF UNDER 1 HRS. Hours Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Blodgett Mo</u>					
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13a. FATHER'S NAME <u>DK</u>		13b. MOTHER'S MAIDEN NAME <u>DK</u>					
14. NAME OF HUSBAND OR WIFE <u>Robert Divinny</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>0</u>					
17. INFORMANT'S SIGNATURE OR NAME <u>George Divinny</u>				ADDRESS <u>Sikeston, Mo</u>							
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinomatosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma Breast, R.</u> DUE TO (c) <u>170X</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1. Diabetic Mellitus</u> <u>2. Diabetic Gangrene, Foot.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6mo</u> <u>2YRS.</u> <u>UNKNOWN</u> <u>3-4 wks.</u>			
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 <u>from June 24, 1955</u> to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) <u>Lidia B. Smith M.D.</u>				23b. ADDRESS <u>Sikeston Mo.</u>		23c. DATE SIGNED <u>6.27.55</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>6-26-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		24d. LOCATION (City, town, or county) (State) <u>Sikeston Mo</u>					
DATE REC'D BY LOCAL REG. <u>6-27-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. [Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Welch Funeral Home - Sikeston Mo</u>							

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

DATE RECEIVED JUL 5 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 655-132

1955 SEP 6

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Raymond Crews
Licensed Embalmer No. 24
P. O. Address Steato

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.