

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7734

State File No. ....

FILED FEB 24 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 29

|  |  |   |                                 |
|--|--|---|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Scott</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u> |                                 |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Sikeston</u> |  | c. LENGTH OF STAY (in this place) <u>2 Days</u>   | c. CITY OR TOWN <u>Sikeston</u> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>          |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>      |                                 |
| STREET ADDRESS (If rural, give location) <u>205 Felker St.</u>                       |  | <u>1003</u>   |                                 |

|  |                           |                          |  |
|--|---------------------------|--------------------------|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Ora</u> | b. (Middle) <u>Lesper</u> | c. (Last) <u>Flowers</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>2</u> <u>9</u> <u>1956</u> |
|--|---------------------------|--------------------------|--|

|                      |                               |   |                                   |   |   |   |
|----------------------|-------------------------------|---|-----------------------------------|---|---|---|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>2-12-1918</u> | 9. AGE (In years last birthday) <u>37</u> | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> | IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u> |
|----------------------|-------------------------------|---|-----------------------------------|---|---|---|

|  |   |  |   |
|--|---|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and State or Foreign Country) <u>Cotton Plant, Arkansas</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
|--|---|--|---|

|   |   |   |
|---|---|---|
| 13a. FATHER'S NAME <u>Darius M. Harelston</u> | 13b. MOTHER'S MAIDEN NAME <u>Annie Piggie</u> | 14. NAME OF HUSBAND OR WIFE <u>Rosevelt Flowers</u> |
|---|---|---|

|   |                                   |   |               |
|---|-----------------------------------|---|---------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) _____ | 16. SOCIAL SECURITY NO. <u>  </u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Annie Harelston, Osceola, Arkansas</u> | ADDRESS _____ |
|---|-----------------------------------|---|---------------|

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|--|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 1/2 hrs.</u> |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Burns, 1, 2 + 3° (80%)</u>   |  |   |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (c) _____ |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Miscarriage, spontaneous (5mo) Epilepsy, Grand Mal.</u>                                 |  |  |   |

|                              |   |  |
|------------------------------|---|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION <u>9160 E 16</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------|---|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><u>Sikeston 14   Scott Mo.</u> |
|--|--|---|

|  |   |  |
|--|---|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>2</u> <u>7</u> <u>56</u> <u>12:15</u> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>House fire</u> |
|--|---|--|

22. I hereby certify that I attended the deceased from 2/7, 1956, to 2/9, 1956, that I last saw the deceased alive on 2/9, 1956, and that death occurred at 7:00 P. m., from the causes and on the date stated above.

|  |  |                                 |
|--|--|---------------------------------|
| 23a. SIGNATURE <u>William J. Biggs, M.D.</u> (Degree or title) | 23b. ADDRESS <u>Sikeston, Missouri</u> | 23c. DATE SIGNED <u>2/13/56</u> |
|--|--|---------------------------------|

|   |                                |  |   |
|---|--------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Feb. 12, 1956</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Addition Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Sikeston, Missouri</u> |
|---|--------------------------------|--|---|

|   |   |  |                                |
|---|---|--|--------------------------------|
| DATE REC'D BY LOCAL REG. <u>2-15-56</u> | REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>J. D. Sparks</u> | ADDRESS <u>Charleston, Mo.</u> |
|---|---|--|--------------------------------|

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

10.300  
0.48

FEB 20 1956

DATE RECEIVED \_\_\_\_\_

SCOTT CO. HEALTH DEPT.

CO. FILE No. 256-45

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 Frank Sparks

Licensed Embalmer No. 34

P. O. Address Cape Hill

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.