

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

83889

State File No.

No. 300
10.48

FILED APR 9 - 1956

BIRTH NO. _____		REG. DIST. NO. <u>387</u>		PRIMARY REG. DIST. NO. <u>5207</u>		Registrar's No. <u>5</u>	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Carroll</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Hill Twp</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>DAWN</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>				e. STREET ADDRESS (If rural, give location) <u>Hill Township 0170</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>IDA</u>			b. (Middle) <u>M</u>		c. (Last) <u>Sykes</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 3, 1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 28, 1873</u>		9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Days <u>6</u>	IF UNDER 24 HRS. Hours <u>5</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, grand retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Utica, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William O. McCracken</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Thompson</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas Sykes</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>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>William T. Sykes, Dawn 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>					<u>2 1/2 mos.</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u>					<u>many years</u>	
	DUE TO (c) <u>General Arteriosclerosis</u>					<u>many years</u>	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>56</u> to <u>Apr. 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar. 15</u> , 19 <u>56</u> , and that death occurred at <u>7A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>G. E. Goldbey M.D.</u>				23b. ADDRESS <u>Raymer, Mo</u>		23c. DATE SIGNED <u>4/3/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>4-5-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Hill Township Mo</u>		
DATE REC'D BY LOCAL REG. <u>APR. 5, 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Rex Henderson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Dickerson Funeral Home Bogard Mo</u>			

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

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..... *R. M. Marshall*

Licensed Embalmer No. *446*

P. O. Address *Carroll*

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.