

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7215

State File No. \_\_\_\_\_

FILED MAR 6 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 37

1. PLACE OF DEATH  
a. COUNTY Scott  
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston  
c. LENGTH OF STAY (in this place) 2 Days  
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mo. Delta Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE Missouri b. COUNTY New Madrid  
c. CITY OR TOWN Morehouse 0720  
d. Is Residence within limits of a city or incorporated town? Yes  No   
e. STREET ADDRESS (If rural, give location) -----

3. NAME OF DECEASED (Type or Print)  
a. (First) Lura b. (Middle) ----- c. (Last) Rowell  
4. DATE OF DEATH (Month) (Day) (Year) 2 16 1957

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married  
8. DATE OF BIRTH 7-29-1886 9. AGE (In years last birthday) 70 6 MONTHS 17 HOURS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife  
10b. KIND OF BUSINESS OR INDUSTRY 0  
11. BIRTHPLACE (City and State or Foreign Country) Webster Co., Mississippi  
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Eldige Hubbard 13b. MOTHER'S MAIDEN NAME Leslie Garey 14. NAME OF HUSBAND OR WIFE F. P. Rowell

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 F. P. Rowell, Morehouse, Mo. 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, asthma, etc. It means the disease, injury, or complication which caused death.  
MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Myocardial infarction  
ANTECEDENT CAUSES DUE TO (b) Arteriosclerotic Cardiovascular Disease  
DUE TO (c) Diabetes Mellitus  
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

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

22. I hereby certify that I attended the deceased from 2-14, 1957, to 2-16, 1957, that I last saw the deceased alive on 2-16, 1957, and that death occurred at 6:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE Alden B. Sargent (Degree or title) M.D. 23b. ADDRESS Sikeston, Mo. 23c. DATE SIGNED 2-20-57

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE 2-18-1957 24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK 24d. LOCATION (City, town, or county) (State) Sikeston, Mo.

DATE REC'D BY LOCAL REG. 2-20-57 REGISTRAR'S SIGNATURE Mrs. Ella Hunter 25. FUNERAL DIRECTOR'S SIGNATURE Welch Funeral Home - Sikeston Mo. ADDRESS -----

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

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DATE RECEIVED FEB 25 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 257-46

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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 Raymond Grews

Licensed Embalmer No. 346

P. O. Address Lickenton

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.