

FILED JUN 21 1957

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

51023223
State File No. 98

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 98

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 OR TOWN <u>SIKESTON</u>) c. LENGTH OF STAY (in this place) <u>4 yrs</u>		c. CITY OR TOWN <u>SIKESTON</u> d. In 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>619 E. GLADYS</u>		e. STREET ADDRESS (If rural, give location) <u>619 E. GLADYS</u> <u>100³</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>EUGENIA</u> b. (Middle) <u>HAMILTON</u> c. (Last) <u>TRIMBLE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5-30-57</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AP. 7 1887</u>	9. AGE (In years last birthday) <u>70</u>	10. F UNDER 1 YEAR <input type="checkbox"/> 11. F UNDER 5 YRS. <input type="checkbox"/>
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 _____	11. BIRTHPLACE (City and State or Foreign Country) <u>ST FRANCIS CO, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>CELESTINE GROGAN</u>		13b. MOTHER'S MAIDEN NAME <u>MARY JEFFRIES</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN R.</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. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Ted Joyce - Sikeston Mo</u> ADDRESS _____	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebro-vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Months</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive cardiovascular disease.</u>		
	DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus, moderate.</u>		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>443x</u>	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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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 4-17, 1957, to 5-30, 1957, that I last saw the deceased alive on 5-30, 1957, and that death occurred at 10:45 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Andrew B. Smith M.D.</u>	23b. ADDRESS <u>217 S. Kingshighway Sikeston, Missouri</u>	23c. DATE SIGNED <u>6-7-57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>6-1-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	24d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>
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DATE REC'D BY LOCAL REG. <u>6-10-57</u>	REGISTRAR'S SIGNATURE <u>Mrs Ella Hunter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Welch Funeral Home - Sikeston Mo</u> ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

429

JUN 17 1957

DATE RECEIVED

SCOTT CO. HEALTH DEPT.

CO. FILE No. 657-129

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 S. Crews

Licensed Embalmer No. 3467

P. O. Address S. Keston

- 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.