

FILED JUN 21 1957

STANDARD CERTIFICATE OF DEATH

57 0 23 225
State File No.

BIRTH NO. <u>28263-57</u>		REG. DIST. NO. <u>333</u>		PRIMARY REG. DIST. NO. <u>3074</u>		Registrar's No. <u>104</u>			
1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>					
b. CITY OR TOWN <u>Sikeston</u>		c. LENGTH OF STAY (in this place) <u>15</u> Hours		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>Mo. Delta Community Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>108 Westgate St.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Roylene</u>			b. (Middle) <u>Arnett</u>		c. (Last) <u>Warren</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>9</u> (Year) <u>1957</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>4-13-1957</u>			
9. AGE (In years last birthday) <u>3</u>		IF UNDER 1 YEAR Months <u>2</u> Days		IF UNDER 18 Hrs. <u></u> Mins. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Sikeston, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME <u>Margaret Warren</u>		14. NAME OF HUSBAND OR WIFE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Margaret Warren, Sikeston, Mo.</u> 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) <u>MALNUTRITION</u> ANTECEDENT CAUSES <u>POOR EATING HABITS.</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u>UNKNOWN.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>2 mo</u> <u>4-5 days</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1. CONVULSIONS, CLONIC, ETIOX</u>		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <u>2</u> 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) <u>7720</u> (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 <u>6-8</u> , 19 <u>57</u> , to <u>6-9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-9</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Andrew B. Sm. Jr. MD</u> (Degree or title)				23b. ADDRESS <u>Sikeston, Mo.</u>		23c. DATE SIGNED <u>6-12-57</u>			
24a. BURIAL: CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-9-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Apts</u>		24d. LOCATION (City, town, or county) (State) <u>Scott Mo</u>			
DATE REC'D BY LOCAL REG. <u>6-14-57</u>		REGISTRAR'S SIGNATURE <u>Mrs. Colla Hunter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dot or funeral services</u>		ADDRESS <u>West Gate.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

429

DATE RECEIVED JUN 17 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 657-123

*This body was not
in Embalmer*

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

589 10512
7-20-57