

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27166

FILED AUG 12 1957

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>333</u>		PRIMARY REG. DIST. NO. <u>3074</u>		Registrar's No. <u>130</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 (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>		c. LENGTH OF STAY (In this place) <u>36 Hrs</u>		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>#2 Bel Air</u> <u>1003</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>W.</u>		b. (Middle) <u>B.</u>		c. (Last) <u>Sikes</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7 29 1957</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7-27-1957</u>	
9. AGE (In years last birthday) _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Sikeston, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William Francis Sikes</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Ann Miller</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) <u>Yes</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>William F. Sikes, Sikeston, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ABNORMAL PULMONARY VENTILATION</u> ANTECEDENT CAUSES DUE TO (b) <u>ATALECTASIS, BILATERAL.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1. PREMATUREITY</u> <u>2. POSSIBLE CNS DAMAGE - BIRTH TRAUMA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>34 hrs</u> <u>34 hrs</u> <u>34 hrs.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7625	
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 <u>7-27</u> , 19 <u>57</u> , to <u>7-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-29</u> , 19 <u>57</u> , and that death occurred at <u>12:05A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Anders [Signature] MD</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>Sikeston, Mo.</u>		23c. DATE SIGNED <u>7-25-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interred</u>		24b. DATE <u>7-29-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sikeston Mausoleum</u>		24d. LOCATION (City, town, or county) (State) <u>Sikeston Mo</u>	
DATE REC'D BY LOCAL REG. <u>8-1-57</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Welsh Funeral Home Sikeston Mo</u>			

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

DATE RECEIVED AUG 5 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 857-156

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 Not Embalmed, 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.