FILED SEP 6 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30549
STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 6115 Registrar's No. 152

1. PLACE OF DEATH
a. COUNTY Scott
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston — Inside Limits Yes ☐ No ☑
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rt. 3 — Length of stay in 1b 1 wk.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Arkansas b. COUNTY Mississippi
c. CITY OR TOWN Osceola — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 105 Mill St. (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Gloria Middle: Antoinette Last: Finley
4. DATE OF DEATH Month: Aug. Day: 26 Year: 1957
5. SEX Female
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb. 24, 1957
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 6 Days 2 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) Osceola Ark.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME T. C. Finley
14. MOTHER'S MAIDEN NAME Eddye Jean Walker
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 J. C. Finley Address Osceola, Ark.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe Diarrhea — INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 5710
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from First Call, after death and last saw her/him alive on ____
Death occurred at 1:50 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thelma C. Burchthorpe, M.D. Health Officer
22b. ADDRESS Benton Mo.
22c. DATE SIGNED 8-27-57

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE
23c. NAME OF CEMETERY OR CREMATORY Pilgrim Rest
23d. LOCATION (City, town, or county) Osceola (State) Ark.

24. FUNERAL DIRECTOR ADDRESS ALVIN DOTSON, SIKESTON, MO.
25. DATE RECD. BY LOCAL REG. 8-27-57
26. REGISTRAR'S SIGNATURE Mrs Ella Hunter

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

This body was not embalmed

DATE RECEIVED SEP 3 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 957-189

1961 6 120

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

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. 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.