

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35053

STATE FILE NUMBER

FILED OCT 21 1957

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 460

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Cape</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Parma</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>S.E. Missouri Hospital</u>		Length of stay in lb <u>13 days</u>	d. STREET ADDRESS (If outside, give location) <u>1313 days</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Gee</u> Last <u>Gee</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>11</u> Year <u>1957</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1884</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	10c. AGE (In years last birthday) <u>73</u>
11. BIRTHPLACE (City and state or country) <u>Stone Fort Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fletcher Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>unknown</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. <u>none</u>	
17. INFORMANT <u>914 S. Otho Gee</u>		Address <u>Vandeventer St. Louis Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Aspiration</u> DUE TO (b) <u>Cerebrovascular Accident</u> DUE TO (c) <u>Cerebral arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>unknown</u> <u>"</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>331X</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. TIME OF INJURY Hour <u>4:45 P.M.</u> Month, Day, Year <u>Sept. 29, 1957</u>	
20c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION <u>Parma, Mo.</u>		20f. COUNTY <u>Cape Girardeau</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>Sept. 29, 1957</u> to <u>Oct. 11, 1957</u> and last saw her alive on <u>Oct. 11, 1957</u> Death occurred at <u>4:45 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Gerald M. Hoxworth, M.D.</u> (Degree or title)		22b. ADDRESS <u>24 N. Spragg Cape Girardeau, Mo.</u>	
22c. DATE SIGNED <u>10/15/57</u>		23. LOCATION (City, town, or county) (State) <u>Malden Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		23b. DATE <u>Oct. 16, 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Malden Mo.</u>	
24. FUNERAL DIRECTOR <u>Watkins Funeral Ser.</u> ADDRESS <u>Parma, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-15-1957</u>	
26. REGISTRAR'S SIGNATURE <u>G. C. Summers</u>			

**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 *Marsh W. Atkins*.....

Licensed Embalmer No. *47*

P. O. Address *Denton*

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.