

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

MARTIN 59-008089

FILED MAR 13 1959

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 41

300
1-57

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, give TOWNSHIP only) OR TOWN <u>SIKESTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SIKESTON</u> <u>1003</u> <u>6</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>507 N. KINGSHIGHWAY</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>507 N. KINGSHIGHWAY</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>LEAH</u> Middle <u>KENDALL</u> Last <u>SIKES</u>			4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>59</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 18 1882</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HARDWARE STORE</u>	11. BIRTHPLACE (City and state or country) <u>SIKESTON MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>DR. O.E. KENDAL</u>	13b. MOTHER'S MAIDEN NAME <u>SUSAN JANE CHANEY</u>	14. NAME OF HUSBAND OR WIFE <u>Alfred C. Sikes</u>
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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>493-36-6833</u>	17. INFORMANT <u>John Sikes</u>	Address <u>Sikeston Mo</u>
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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>Edema, pulmonary</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4260</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from _____ to _____ and last saw ^{her} _{him} alive on _____ Death occurred at <u>9:40 AM</u> upon the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>[Signature]</u>	22b. ADDRESS <u>Sikeston MO</u>	22c. DATE SIGNED <u>3-7-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAUSOLEUM</u>	23d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>
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24. FUNERAL DIRECTOR <u>Welsh Funeral Home - Sikeston Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-7-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Lotnumber, etc. must use only standard nomenclature in item 18. All diseases in Part I must be causally related.

MAR 9 1 1959

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 Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo.

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.