

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022011

FILED VS MAY 19 1960

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 122

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>SCOTT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>		c. CITY OR TOWN <b>SIKESTON</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Comm. Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>206 RUTH</b>	

3. NAME OF DECEASED (Type or print) First <b>NORA</b> Middle <b>HENDERSON</b> Last <b>SHANNON</b>			4. DATE OF DEATH Month <b>5</b> Day <b>6</b> Year <b>1960</b>	
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-27-1878</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>KY</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>MARION PIERCE</b>	13b. MOTHER'S MAIDEN NAME <b>GRIZELDA FRANCES PEPPER</b>	14. NAME OF HUSBAND OR WIFE <b>FRANK</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>493-07-2037A</b>	17. INFORMANT <b>Fred Cole - Sikeston Mo</b>	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Carcinoma of Colon</b>		<b>Unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Causing obstruction of bowel</b>	<b>3 days</b>
	DUE TO (c) <b>Senile Psychia</b>	<b>3 years</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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 **March 6 - 60** and last saw her alive on **March 6 - 1960**  
Death occurred at **12:25 P.** m on the **6** date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE (Degree or title) <b>Thomas C. McClure M.D.</b>	22b. ADDRESS <b>Sikeston, Mo.</b>	22c. DATE SIGNED <b>5/9/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5-8-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City</b>	23d. LOCATION (City, town, or county) <b>SIKESTON MO</b>
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24. FUNERAL DIRECTOR <b>Welch Funeral Home - Sikeston Mo</b>	ADDRESS <b>Sikeston Mo</b>	25. DATE RECD. BY LOCAL REG. <b>5-11-60</b>	26. REGISTRAR'S SIGNATURE <b>Max Cole Hunter</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
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 Leicester St

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.