

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025487

ED VS JUN 16 1960

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 145

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>		Length of stay in 1b <u>34 YRS.</u>	c. CITY OR TOWN <u>SIKESTON</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>106 WESTGATE ST</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>106 WEST GATE ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MITTIE</u> <u>MURPHY</u>			4. DATE OF DEATH Month Day Year <u>6 - 2 - 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>LITTLE ROCK, ARK</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>-</u>		13b. MOTHER'S MAIDEN NAME <u>LUCY MC. DONALD</u>		14. NAME OF HUSBAND OR WIFE <u>-</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.	17. INFORMANT <u>ROWENA HARRISON, DETROIT, MICH.</u>	Address <u>3130 HEIDELBERG</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>Cerebral Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
DUE TO (b) <u>Arteriosclerotic vascular disease</u>		<u>indefinite</u>
DUE TO (c)		
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

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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.  
Death occurred at approximately 11:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree optional) <u>John P. Sargent, M.D.</u>		22b. ADDRESS <u>707 Tanner Street Sikeston, Missouri</u>	22c. DATE SIGNED <u>6-9-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-5-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET</u>	23d. LOCATION (City, town, or county) (State) <u>SIKESTON, MO</u>
24. FUNERAL DIRECTOR <u>ALVIN DOTSON, SIKESTON, MO.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>6-10-60</u>	26. REGISTRAR'S SIGNATURE <u>Marjorie Hunter</u>

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.  
Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Tris E. Marshall

Licensed Embalmer No. 4160

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.