

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025492

FILED VS JUL 7 1960 333

STATE FILE NUMBER

Registration District No. 3074 Registrar's No. 160

ENDED

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Scott</u>   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Stoddard</u> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Sikeston</u>  |   | Length of stay in 1b<br><u>1wk.</u>   | c. CITY OR TOWN <u>Bloomfield</u>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Mo Delta Community Hosp</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>Ardelia</u> Last <u>HARRIS</u> <sup>TOWERY</sup> <u>SCOTT</u>  |   |   | 4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>60</u>   |  |   |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-3-1871</u>  | 9. AGE (last birthday)<br><u>88</u>  | IF UNDER 1 YEAR<br>Months <u>9</u> Days <u>19</u>                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>household</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Stoddard Co. Mo.</u>  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>   |   |
| 13a. FATHER'S NAME<br><u>George Stacy</u>   |   | 13b. MOTHER'S MAIDEN NAME<br><u>Nancy Higaw</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>D. J. Scott</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (If yes, give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  | 17. INFORMANT Address<br><u>MRS. Troy Tippet, Matthews, Mo.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage -</u><br>DUE TO (b) <u>Cerebral Atherosclerosis -</u><br>DUE TO (c) <u>Hypertension,</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>years</u><br><u>years</u>     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Arteriosclerotic Heart Disease</u>  |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____<br>a.m. _____<br>p.m. _____   | Month, Day, Year  |   |  |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <u>1-6-60</u> to <u>6-22-60</u> and last saw her <sup>him</sup> alive on <u>6-22-60</u><br>Death occurred at <u>5:55</u> <u>P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |  |  |   |
| 22a. SIGNATURE (Degree or title)<br><u>Stephen Taylor M.D.</u>  |   | 22b. ADDRESS<br><u>Bloomfield Mo</u>  |  | 22c. DATE SIGNED<br><u>6-25-60</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE<br><u>6-24-60</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Pleasant Grove Cemetery</u>  |  | 23d. LOCATION (City, town, or county)<br><u>Stoddard Co. Mo.</u>   |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>W<sup>o</sup> H. MORGAN, ADVANCE, Mo</u>   |   | 25. DATE RECD. BY LOCAL REG.<br><u>June 29 '60</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Ellen 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 W<sup>m</sup> H Morgan

Licensed Embalmer No. 4640

P. O. Address Advance, S.

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