URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-037148

FILED VS OCT 3 1960

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 229

STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY Scott
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY NEW MADRID
c. CITY OR TOWN RURAL — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) CATRON RFD #1 — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First RUTH Middle ANN Last MITCHELL

4. DATE OF DEATH Month 9 Day 18 Year 1960

5. SEX Female
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 10-1-1874
9. AGE (last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY AT HOME
11. BIRTHPLACE (City and state or country) GIRARD KAN
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME JAMES SCOFIELD
13b. MOTHER'S MAIDEN NAME MARTHA POTTER
14. NAME OF HUSBAND OR WIFE HENRY A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Fred Mitchell · Address Canalou Mo

18. CAUSE OF DEATH (Enter only one cause ~~per line for (a)~~ (b), and (c).

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thrombosis of Illiac arteries — INTERVAL BETWEEN ONSET AND DEATH 1 day

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 9-18-60, to 9-18-60 and last saw her alive on 9-18-60
Death occurred at 10:40 P.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) S. M. Sarno, M.D.
22b. ADDRESS Sikeston, Mo.
22c. DATE SIGNED 9-20-60

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 9-20-60
23c. NAME OF CEMETERY OR CREMATORY GARDEN OF MEMORIES
23d. LOCATION (City, town, or county) (State) SIKESTON MO

24. FUNERAL DIRECTOR ADDRESS Welsh Funeral Home - Sikeston Mo
25. DATE RECD. BY LOCAL REG. 9-22-60
26. REGISTRAR'S SIGNATURE ~~9-22-60~~ Mrs Letta Hunter

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 _____ Signed Raymond Grews

Signature of Student Embalmer

Licensed Embalmer No. 3467

P. O. Address Siteston

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