

MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. 333 PRIMARY REGISTRATION DISTRICT NO. 3074 REGISTRAR'S NO. 262 STATE FILE NUMBER -60-040731

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>		c. CITY OR TOWN <u>SIKESTON</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>418 RUTH ST.</u>		d. STREET ADDRESS (If outside, give location) <u>418 RUTH ST</u>	

3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>HENRY</u> Last <u>PAGE SR</u>			4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>60</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1873</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____
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>GROCERYMAN</u>	11. BIRTHPLACE (City and state or country) <u>CAPE GIRARDEAU MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>NATHALIN PAGE</u>		13b. MOTHER'S MAIDEN NAME <u>MARY BERRY</u>		14. NAME OF HUSBAND OR WIFE _____	

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>D.H. Page Jr. Sikeston Mo</u> Address _____	
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 Neurosclerosis</u> DUE TO (b) <u>GENERAL. ART. SCLEROSIS</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>8 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>DIABETES MELLITUS -</u>				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 _____ a.m. _____ p.m. Month, Day, Year _____					

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1958</u>	20f. CITY, TOWN, OR LOCATION <u>10. 27. 60</u>	COUNTY _____	STATE _____
21. I attended the deceased from <u>10. 27. 60</u> to <u>10. 27. 60</u> and last saw him alive on <u>10. 26. 60</u> . Death occurred at <u>3:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Carl L. Papp M.D.</u>	(Degree or title)	22b. ADDRESS <u>Sikeston</u>	22c. DATE SIGNED <u>11. 2. 60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-29-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>
24. FUNERAL DIRECTOR <u>Welsh Funeral Home - Sikeston Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-2-60</u>	26. REGISTRAR'S SIGNATURE <u>Miss Ella 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 _____
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 Likeston

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.