

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048439

FILED 93 JAN 9 1961 333

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 304

STATE FILE NUMBER

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>		Length of stay in 1b <b>7 Mon. 12 Days</b>		c. CITY OR TOWN <b>Sikeston</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
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>1723 Allen Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Terry</b> Middle <b>Tyrone</b> Last <b>Reason</b>			4. DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-10-1960</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months <b>7</b> Days <b>12</b> IF UNDER 24 HR Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Sikeston, Missouri U.S.A.</b>		
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <b>Minnie Lee Reason</b>		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)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Minnie Lee Reason, Sikeston, Mo.</b> 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) <b>Diarrhea - Enteric</b>					INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
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. <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 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 <b>12-21-60</b> to <b>12-23-60</b> and last saw her him alive on <b>12-23-60</b> Death occurred at <b>9-15 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>Alvin Dotson M.D.</i>			22b. ADDRESS <b>Sikeston, Missouri</b>		22c. DATE SIGNED <b>12-25-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>12-24-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset of Memory</b>		23d. LOCATION (City, town, or county) (State) <b>Sikeston Missouri</b>		
24. FUNERAL DIRECTOR <b>Alvin Dotson, Sikeston, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>12-29-1960</b>		26. REGISTRAR'S SIGNATURE <i>Max Ella Hunter</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

This body was not Embalmed  
Alvin Watson

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.