

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-039804

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 209

FILED OCT 30 1961

1. PLACE OF DEATH a. COUNTY <u>Scott</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</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	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>Mo. Delta Comm. Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>311 Petty St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CATHEY</u> Middle <u>DAVIS</u> Last <u>DAVIS</u>			4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1961</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 type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-1960</u>	9. AGE (last birthday) <u>10</u> Months <u>10</u> Days	IF UNDER 1 YEAR Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Betrand, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Mamie Davis</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)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mamie Davis, Sikeston, Mo.</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>Toxemia, Gastro-intestinal hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Burns -</u>					<u>3 days.</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) <u>NONE</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>House fire -</u>			
20c. TIME OF INJURY Hour <u>2</u> p.m. Month, Day, Year <u>Oct 20 '61</u>	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>HOME</u>	20f. CITY, TOWN, OR LOCATION <u>Sikeston</u>	COUNTY <u>Scott</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>10/20/61</u> to <u>10/23/61</u> and last saw her/him alive on <u>10/23/61</u> . Death occurred at <u>10:55 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Joseph C. Bouton MD</u> (Degree or title)			22b. ADDRESS <u>1012 N. Main, Sikeston, Mo.</u>		22c. DATE SIGNED <u>10/23/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-24-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset of Memory</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>10-24-61</u>	26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>	

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

This body was not Embalmed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
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.