

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-010032

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 2074 Registrar's No. 47

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1007

206752

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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>Mississippi</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		Length of stay in 1b <u>15 hrs.</u>	c. CITY OR TOWN <u>Charleston</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 Community</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>601 W. Pecan</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>MaE</u> Last <u>Haynes</u>			4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>63</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1916</u>
9. AGE (last birthday) <u>47</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>2</u>	IF UNDER 24 HR Hours <u>3</u> Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Egypt</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13. NAME OF HUSBAND OR WIFE	
13a. FATHER'S NAME <u>Sam Bailey</u>		13b. MOTHER'S MAIDEN NAME <u>Rosemary Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rosemary Clark</u>		Address <u>601 W. Pecan</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Hypertension -</u> <u>Hypertensive Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
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 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. _____		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 <u>2-14-63</u> to <u>2-15-63</u> and last saw her alive on <u>2-15-63</u> Death occurred at <u>5:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u>		22b. ADDRESS <u>[Signature]</u>	
22c. DATE SIGNED <u>2-15-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-23-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Charleston md</u>	
24. FUNERAL DIRECTOR <u>Dennis Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>2-20-63</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

USE BLACK INK OR TYPEWRITER RIBBON

APR 2 1963

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 Willie R. Davis

Licensed Embalmer No. 5129

P. O. Address Charleston S.C.

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.