

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-018755

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 112

FILED MAY 1 1963

1. PLACE OF DEATH a. COUNTY SCOTT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY NEW MADRID	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN SIKESTON		Length of stay in 1b 9 days	c. CITY OR TOWN MOREHOUSE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION MO. DELTA COMMUNITY HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) GENERAL DELIVERY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) IDA JANE REEVES	4. DATE OF DEATH 4-24-63
---------------------------------------------------------------	------------------------------------

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan 2, 1879	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months 5 Days 22	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------	-------------------------------------	---------------------------------------------------	----------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home wife	10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (City and state or country) Leana, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
-----------------------------------------------------------------------------------------------------------------	----------------------------------------------	-----------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME Frank Dodge	13b. MOTHER'S MAIDEN NAME Mary Jones	13c. NAME OF HUSBAND OR WIFE John Reeves
------------------------------------------	------------------------------------------------	----------------------------------------------------

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 Stella Poe, Casualty, Mo. Address
---------------------------------------------------------------------------------------------------------------------	------------------------------------	----------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic c.v. Disease with cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 year
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 checked="" 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 Month, Day, Year 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 4-1-63 to 4-24-63 and last saw her alive on 4-24-63
Death occurred at 3:38 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature]	(Degree or title) M.D.	22b. ADDRESS Morehouse, Mo.	22c. DATE SIGNED 4-25-63
--------------------------------------	----------------------------------	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Apr. 26, 1963	23c. NAME OF CEMETERY OR CREMATORY Garden of Memories Sikeston, Mo.	23d. LOCATION (City, town, or county) (State) Sikeston, Mo.
------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------------------	-----------------------------------------------------------------------

24. FUNERAL DIRECTOR [Signature] ADDRESS Sikeston, Mo.	25. DATE RECD. BY LOCAL REG. April 27, 1963	26. REGISTRAR'S SIGNATURE [Signature]
-------------------------------------------------------------------------------	-------------------------------------------------------	-------------------------------------------------

(Licensed Embalmer's statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 1007

2 0720

3

4 1

5 1

6

7 0

8 2

94221

10

11

12 1-0

13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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

Raymond L. Duffie

Licensed Embalmer No. 4798

P. O. Address Berrie, Mo.

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.

Berrie, Mo. April 25 - 1963