

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-031566

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 406

STATE FILE NUMBER

FILED SEP 13 1963

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU CO.</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>CAPE GIRARDEAU</u>		Length of stay in 1b <u>7 day</u>	c. CITY OR TOWN <u>SIXESTON</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>S.E. Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>415 N. Kings Highway</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIAN JOSEPHINE DERRIS</u>			4. DATE OF DEATH Month Day Year <u>9 - 1 - 1963</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-1885</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>7 23</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WIFE</u>	11. BIRTHPLACE (City and state or country) <u>ALTON ILL.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
---	--	---	---

13a. FATHER'S NAME <u>WILLIAM HENRY BROOKS</u>	13b. MOTHER'S MAIDEN NAME <u>GENEVA STAPP</u>	14. NAME OF HUSBAND OR WIFE <u>WALTER</u>
---	--	--

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. <u>[REDACTED]</u>	17. INFORMANT Address <u>Walter Dennis Siggeston 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>acute congestive heart failure.</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
---	--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>generalized arteriosclerosis</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 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 9/29/63 to 9/1/63 and last saw her alive on 9/1/63
Death occurred at 5 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. H. Keim M.D.</u>	22b. ADDRESS <u>Cape Girardeau Mo</u>	22c. DATE SIGNED <u>9/7/63</u>
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-3-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>CAPE GIRARDEAU MO.</u>
--	------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>Wells Funeral Home Sixeston Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 9, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Walter Hasten</u>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

10168

21007

3

4 1

5 1

6

7 1

8 2

94200

10

11

12 3-0

13 Mo

USE BLACK INK OR TYPEWRITER RIBBON

SEP 16 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 Raymond News

Licensed Embalmer No. 3467

P. O. Address Si Keaton 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.