

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-050510**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 6

**FILED JAN 6 1964**

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>3yr</b>	c. CITY OR TOWN <b>Sikeston, Mo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Shuffit Nursing Home</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>233 Moore</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Emma</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>12</b> Day <b>29</b> Year <b>63</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-11-74</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months Days Hours 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>Carbondale, Ill</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13a. FATHER'S NAME <b>Charles C. Thomas</b>		13b. MOTHER'S MAIDEN NAME <b>Dora E. Mayhew</b>		14. NAME OF HUSBAND OR WIFE <b>William J. Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Charles C. Thomas Jr. Brother</b>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>36 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) <b>Schility and Arteriosclerosis</b>					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 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>Jan 1961</b> to <b>12-29-63</b> and last saw her alive on <b>12-28-63</b> Death occurred at <b>2:45 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>John P. Sargent, M.D.</b>			22b. ADDRESS <b>808 East Wakefield Sikeston Missouri</b>		22c. DATE SIGNED <b>1-2-64</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 31, 63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carbondale Ill</b>	
24. FUNERAL DIRECTOR <b>Delta Funeral Chapel Sikeston, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>Jan 3 1964</b>	26. REGISTRAR'S SIGNATURE <b>Jeanette Waldman</b>	

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
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 MEDICAL CERTIFICATION  
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(Licensed Emballer's Statement on Reverse Side)

1-1-1963

Permit Renewal Fee \$0.15 & 3

**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 Elgin McMillan

Licensed Embalmer No. 4695

P. O. Address Charleston 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.