

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006810

STATE FILE NUMBER

FILED MAR 3 1959

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 78

300
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Farmington, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Farmington, Mo.</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		Length of stay in 1b	d. STREET ADDRESS <u>312 Pine St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Birdie</u> Middle <u>Ross Anna</u> Last <u>Easter</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>March 30, 1884</u>	9. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR Months <u>10</u> Days <u>24</u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cape Girardeau County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Benjamin F. Sides</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Catherine Hughes</u>		14. NAME OF HUSBAND OR WIFE	
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.	17. INFORMANT Address <u>Mrs. Virginia Doblin Farmington, 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>Arteriosclerotic heart diseases</u>					INTERVAL BETWEEN ONSET AND DEATH <u>year</u>
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) <u>Carcinoma of Lt. Breast.</u>					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 <input type="checkbox"/> NOT WHILE 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>1955</u> to <u>February 24, 1959</u> and last saw her alive on <u>February 23, 1959</u> Death occurred at <u>2:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R. A. Huckstep</u> (Degree or title)			22b. ADDRESS <u>301 W. Liberty Farmington, Mo.</u>		22c. DATE SIGNED <u>2-25-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 26, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Farmington, Mo.</u>
24. FUNERAL DIRECTOR <u>C. H. Cozean Farmington, Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>Feb. 25, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Ether Redloff</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MAR 6 1959

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
C. H. Cozlar

Licensed Embalmer No. *4084*

P. O. Address *Farmington*

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.