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APR 15 1941

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **11494**

Registration District No. **608**

Primary Registration District No. **807**

Registrar's No. **11**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Stella  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Cardwell Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry

(c) City or town Exeter  
(If outside city or town limits, write "RURAL")

(d) Street No. 1  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mellie Bernice Rinn

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 15  
year 1941 hour 10 minute 7 M.

21. I hereby certify that I attended the deceased from March 15  
\_\_\_\_\_, 1941, to March 15, 1941;  
that I last saw her alive on March 15, 1941;  
and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife W.M. Rinn

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased December 24 1872  
(Month) (Day) (Year)

Immediate cause of death  
Cerebral Hemorrhage  
with meningeal infection

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>2</u>	<u>21</u>	hr. _____ min. _____

9. Birthplace Molan County Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name William Madrox

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Margie Pennel

15. Birthplace Molan County Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Ruth Col

(b) Address Exeter, Mo R#1

17. (a) Burial (b) Date thereof 3-19-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maplewood Cem.

18. (a) Signature of funeral director G. Von Funn, Home

(b) Address Cassville

19. (a) 3/16/41 (b) Aida Colling  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature W.R.M. Clure (M.D. or other) D.O.

Address Cassville Date signed 3/16/41

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number

441-592

Date Filed

APR 10 1941

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Ervin Wood*

Licensed Embalmer No. *3804*

P. O. Address *Cassville, 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 this body is not embalmed, fact should be so stated above.