

FILED OCT 17 1946

State File No. _____

Registration District No. 4

Primary Registration District No. 4021

Registrar's No. 11

1. PLACE OF DEATH:

(a) County AUDRAIN.
(b) City or town LADDONIA - MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 50 YRS. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County AUDRAIN
(c) City or town LADDONIA.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SUSAN QUAINANCE

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWER

6. (b) Name of husband or wife JOHN QUAINANCE 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 24 1865
(Month) (Day) (Year)

8. AGE: Years 81 Months 5 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace MALTA, MORGAN OHIO
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWORK.

11. Industry or business HOME.

12. Name ARTHUR CORNER STEEL

13. Birthplace MORGAN CO OHIO
(City, town, or county) (State or foreign country)

14. Maiden name MARTHA COLE

15. Birthplace MORGAN CO OHIO
(City, town, or county) (State or foreign country)

16. (a) Informant John Quainance

(b) Address Haddington - TEXAS.

17. (a) BURIAL. (b) Date thereof SEPT. 27 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LADDONIA - MO.

18. (a) Signature of funeral director Clyde E. Wilsey

(b) Address LADDONIA MO.

19. (a) Sept 30 (b) Martha Quainance
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 26
year 1946 hour 1:30 minute A. M.

21. I hereby certify that I attended the deceased from Sept 8 1946 to Sept 26 1946
that I last saw her alive on Sept 25 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction
Johns Chimerama Duration 2 Days

Due to Fracture neck of right femur Duration 18 Days

Other conditions (Include pregnancy within 3 months of death) _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations _____ Of autopsy _____
Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) _____ 4

(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. T. McCall (M. D. or other) _____

Address Laddonia, Mo Date signed 9-29-46

RECEIVED
District Health Officer No. 10
Dist. No. 1946-1625
OCT 14 1946
Bos. File

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

Blyde C. Wilke

Licensed Embalmer No. *3820*

P. O. Address *Perry, Ind.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 11

Registration District No. 8 Primary Registration District No. 4021

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town Jadonia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Susan Aumantave
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased April (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 81 Months 5 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) Ohio

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1946 hour _____ minute _____ M. 6
21. I hereby certify that I attended the deceased from _____ to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
1946
18

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident L
(b) Date of occurrence September 9- '46 L
(c) Where did injury occur? Radonin, Andrew, Mo L
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home L
While at work? yes (Specify type of place) (e) Means of injury fall L
23. Signature W.H. McCall (M. D. or other) _____
Address Radonin, Mo Date signed 11-23-46

SUPPLEMENTARY

WHILE I REMAIN - USE ORENDING BLACK INK - MAKE A PERMANENT RECORD

31458

32628