

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33944**

FILED NOV 15 1947

Registration District No. **62**

Primary Registration District No. **5251**

Registrar's No. **33**

1. PLACE OF DEATH:

(a) County: **CHARITON**
(b) City or town: **Mendon Rural**
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **MISSOURI** County: **Chariton**
(b) City or town: **Mendon Rural**
(If outside city or town limits, write "RURAL")
(c) Street No.:
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: **MARY M. Rhine**
3. (b) If veteran, name war:
3. (c) Social Security No.:

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **28th.**
year **1947** hour **5** minute **-** P.M.
21. I hereby certify that I attended the deceased from **Sept. 7th.** 19**47**, to **Sept. 28th** 19**47**, that I last saw her alive on **Sept. 26th.** 19**47**, and that death occurred on the date and hour stated above.

4. Sex: **F**
5. Color or race: **W**
6. (a) Single, widowed, married, divorced: **MARRIED**
6. (b) Name of husband: **FRANK Rhine**
6. (c) Age of husband or wife if alive: **73** years
7. Birth date of deceased: **Aug 11** 18**66**
(Month) (Day) (Year)

Immediate cause of death: **Acute cardiac failure**
Due to: **Senility**
Due to: **Malnutrition**
Other conditions (Include pregnancy within 3 months of death):
Major findings:
Of operations:
Of autops:

8. AGE: Years Months Days If less than one day
81 / **1** / **17** hr. min.

9. Birthplace: **Marion Co. Iowa**
(City, town, or county) (State or foreign country)
10. Usual occupation: **Housewife**

11. Industry or business:
12. Name: **William Browning**
13. Birthplace: **Virginia**
(City, town, or county) (State or foreign country)
14. Maiden name: **Lucretia Bryant**
15. Birthplace: **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Frank Rhine**
(b) Address: **Mendon Mo**

17. (a) **Funeral** (Burial, cremation, or removal) (b) Date thereof: **9/30/47**
(Month) (Day) (Year)
(c) Place: burial or cremation: **Newcomer**

18. (a) Signature of funeral director: **S. Heipand**
(b) Address: **Mendon MO**

19. (a) **Sept 30, 47** (Date received local registrar) (b) **milled home** (Registrar's signature)

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 * **2**
23. Signature: **N. P. Fowler** (M. D. or other) **D. O.**
Address: **Brunswick, Mo.** Date signed: **9/29/47**

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

MOTHER FATHER

Duration
ter.
5yrs.
6mo.
PHYSICIAN
Underline the cause of which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

File Number _____

Filed 11-14-47

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, ~~and~~ _____

Registered Apprentice No. _____

working under my personal supervision.

Signed A. L. Leopard

Licensed Embalmer No. 3970

P. O. Address Newton Me

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.