

FILED APR 20 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 11777

BIRTH NO.		REG. DIST. NO. <u>55</u>		PRIMARY REG. DIST. NO. <u>3011</u>		Registrar's No. <u>34</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <b>Carroll</b>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Carrollton</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>Carroll</b>	
c. LENGTH OF STAY (in this place) <b>18 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Carrollton</b>		d. STREET ADDRESS (If rural, give location) <b>501 West Heida.</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Staton Clinic 3</b>				d. STREET ADDRESS (If rural, give location) <b>501 West Heida.</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Mary</b>		b. (Middle) <b>Alice</b>		c. (Last) <b>Doane</b>	
4. DATE OF DEATH		(Month) <b>4</b>		(Day) <b>9</b>		(Year) <b>1949</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Oct. 14th, 1857</b>	
9. AGE (In years last birthday) <b>91</b>		IF UNDER 1 YEAR Months <b>5</b>		IF UNDER 24 HRS. Days <b>25</b>		Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Work</b>		11. BIRTHPLACE (State or foreign country) <b>Canada 2</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>George McNish</b>		13b. MOTHER'S MAIDEN NAME <b>Lavenia Purvis</b>		14. NAME OF HUSBAND OR WIFE <b>Charles Doane</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>James McNish Carrollton Mo.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		<b>Myocardial Insufficiency (Exhaustion)</b>				<b>20 da.</b>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Fractured hip</b>				<b>20 da.</b>	
DUE TO (c)		<b>Fractured hip</b>				<b>20 da.</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4/9/49</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Carrollton, Carroll, Mo.</b>			
21d. TIME OF INJURY <b>Mar 23/49 5:30 p.m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Fell on stairs way</b>			
22. I hereby certify that I attended the deceased from <b>Mar 22, 1949</b> , to <b>April 9, 1949</b> , that I last saw the deceased alive on <b>April 9, 1949</b> , and that death occurred at <b>5:29 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>J. H. Stinson</b>				(Degree or title) <b>M.D.</b>		23b. ADDRESS <b>Carrollton, Mo.</b>	
23c. DATE SIGNED <b>April 10 1949</b>		23d. SIGNATURE <b>Mrs. W. H. Stinson</b>		23e. ADDRESS <b>Carrollton, Mo.</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>4-11-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Brookfield</b>		24d. LOCATION (City, town, or county) (State) <b>Mo. Mo</b>	
DATE REC'D BY LOCAL REG. <b>4/11/49</b>		REGISTRAR'S SIGNATURE <b>Mrs. W. H. Stinson</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall Funeral Home</b>		ADDRESS <b>Carrollton</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 4-19-49

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 .....  
Student Embalmer

Signed *P. Marshall*

Licensed Embalmer No. 7469

P. O. Address Carrollton

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.