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

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 187

1. PLACE OF DEATH
 a. COUNTY Livingston
 b. CITY OR TOWN Chillicothe
 c. LENGTH OF STAY (in this place) 7 days
 d. FULL NAME OF HOSPITAL OR INSTITUTION Chillicothe Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
 a. STATE Missouri b. COUNTY Livingston
 c. CITY OR TOWN Avalon, Mo.
 d. STREET ADDRESS 0550

3. NAME OF DECEASED
 (Type or Print)
 a. (First) Ann b. (Middle) Alina c. (Last) Rickenbrode

4. DATE OF DEATH
 (Month) (Day) (Year)
10-20-50

5. SEX Female

6. COLOR OR RACE White (US)

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH 11-29-60

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
OHIO

12. CITIZEN OF WHAT COUNTRY?
USA

13a. FATHER'S NAME
Joseph Davenport Roberts

13b. MOTHER'S MAIDEN NAME
Harriet L. Carmex

14. NAME OF HUSBAND OR WIFE
F.W. Rickenbrode

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME
Holton Roberts Rickenbrode, Avalon, Mo.

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
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis
 ANTECEDENT CAUSES
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
 DUE TO (b) _____
 DUE TO (c) _____
 II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
1 1/2 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
 YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)
Chillicothe Riv. MO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 16, 1950 to 10-20-50, 1950, that I last saw the deceased alive on 10-20-50, 1950, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
D. M. Dawell, M.D.

23b. ADDRESS
Chillicothe Mo

23c. DATE SIGNED
10-23-50

24a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24b. DATE
10-23-50

24c. NAME OF CEMETERY OR CREMATORY
Avalon

24d. LOCATION (City, town, or county) (State)
Avalon, Missouri

DATE REC'D BY LOCAL REG.
10/23/50

REGISTRAR'S SIGNATURE
Francis B Neill

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Norman Funeral Home, Chillicothe, Mo.



NOV 8 1950

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Joseph M. Gibson*

Licensed Embalmer No. *4769*

P. O. Address *Chillicothe, 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.