

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

24172

State File No. _____

No. 300
10. 48

FILED JUL 26 1951

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|--|--|--|--|---|--|---|---|
| BIRTH NO. _____ | | REG. DIST. NO. <u>311</u> | | PRIMARY REG. DIST. NO. <u>4456</u> | | Registrar's No. <u>111</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>St. Clair</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St. Clair</u> | | | |
| b. CITY OR TOWN <u>Appleton City</u> | | c. LENGTH OF STAY (in this place) <u>4 wks.</u> | | c. CITY OR TOWN <u>Appleton City, Mo</u> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Elliott Hosp.</u> | | | | d. STREET ADDRESS (If rural, give location) <u>0930</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Javina</u> c. (Last) <u>Dingus</u> | | | 4. DATE OF DEATH (Month) <u>July</u> (Day) <u>20</u> (Year) <u>1951</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>May 20 1872</u> | | 9. AGE (in years last birthday) <u>79</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>1</u> | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTH PLACE (State or foreign country) <u>Arrow Rock Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>D. Jawless</u> | | 13b. MOTHER'S MAIDEN NAME <u>Martha Dawson</u> | | 14. NAME OF HUSBAND OR WIFE <u>Chas Dingus</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>W. Schickler</u> ADDRESS <u>Lumburg Mo.</u> | | | |
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> 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 _____ | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 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) <u>331X</u> (COUNTY) _____ (STATE) _____ | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | | | |
| 22. I hereby certify that I attended the deceased from <u>21 July 1951</u> , to <u>20 July 1951</u> , that I last saw the deceased alive on <u>20 July 1951</u> , and that death occurred at <u>10:45 pm.</u> , from the cause and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>W. Schickler</u> (Disease or title) | | | | 23b. ADDRESS <u>Appleton City</u> | | 23c. DATE SIGNED <u>21 July 51</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>7-22-51</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Appleton City Cem.</u> | | 24d. LOCATION (City, town, or county) <u>Appleton City, Mo</u> (State) _____ | | |
| DATE REC'D BY LOCAL REG. <u>July 22-1951</u> | | REGISTRAR'S SIGNATURE <u>Chas. Aubrey</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Schickler</u> ADDRESS <u>Appleton City, Mo</u> | | | |

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

RECEIVED 7-25-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 7-25-51 _____

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 Oscar Eckhoff

Licensed Embalmer No. 3942

P. O. Address Appleton City

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.