

RECEIVED OCT 17 1951

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

State File No. **32843**
Registrar's No. **83**

BIRTH NO. _____		REG. DIST. NO. 52		PRIMARY REG. DIST. NO. 4078	
1. PLACE OF DEATH a. COUNTY Cape Girardeau			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE mo b. COUNTY Cape Girardeau		
b. CITY (If outside corporate limits, write RURAL and give township) Delta Mo		c. LENGTH OF STAY (If in this place) 11 days		c. CITY (If outside corporate limits, write RURAL and give township) Delta Allenville mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION her grand daughter's home			d. STREET ADDRESS (If rural, give location) Delta mo		
3. NAME OF DECEASED (Type or Print) a. (First) Minnie Adeline b. (Middle) Amos c. (Last) Amos			4. DATE OF DEATH (Month) (Day) (Year) Oct 5 51		
5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	
8. DATE OF BIRTH July 8 - 1872		9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) White water mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Frederick Brase		13b. MOTHER'S MARRIEN NAME Sarah Adams	
14. NAME OF HUSBAND OR WIFE Robert M. Amos		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Wesley J. Chas. Jackson mo		18. ADDRESS 416 X		19. STATE 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) arteriosclerosis and rheumatic heart ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Old age DUE TO (c) _____ 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 none		
20. AUTOPSY? YES ☐ NO ☒		21a. ACCIDENT SUICIDE HOMICIDE (Specify) none		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		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 June 1st 1951 , to Oct 5 1951 , that I last saw the deceased alive on Oct 5 1951 , and that death occurred at 7:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE W. J. Chas. Jackson		23b. ADDRESS Delta mo		23c. DATE SIGNED Oct 5 51	
24a. BURIAL, CREMATION, OR OTHER DISPOSITION buried		24b. DATE 10-7-51		24c. NAME OF CEMETERY OR CREMATORY Kaman	
24d. LOCATION (City, town, or county) (State) Allenville, Cape Gir. Co. mo		25. FUNERAL DIRECTOR'S SIGNATURE D. E. Seibert		25. ADDRESS M. C. Combs Funeral Home, Jackson	
DATE REC'D BY LOCAL REG. Oct 7-51		REGISTRAR'S SIGNATURE D. E. Seibert			

(Licensed Embalmer's Statement on Reverse Side)

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

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DISTRICT HEALTH OFFICE No. 6

File No.

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 _____

Signed _____
Student Embalmer

Licensed Embalmer, No. 4055

P. O. Address _____

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.