

FILED NOV 13 1951

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

34617

State File No.

BIRTH NO. _____ REG. DIST. NO. 277 PRIMARY REG. DIST. NO. 4411 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bowling Green</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LOUISIANA</u>	
c. LENGTH OF STAY (in this place) <u>19 MONTHS</u>		d. STREET ADDRESS (If rural, give location) <u>1317 KENTUCKY ST</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>B.B. SPRINGS SANITARIUM</u>			

3. NAME OF DECEASED (Type or Print): a. (First) <u>EMMA</u> b. (Middle) <u>MINNESOTA</u> c. (Last) <u>LIMBRICK</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 20, 1951</u>		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED 2</u>	
8. DATE OF BIRTH <u>JUNE 24, 1865</u>		9. AGE (In years last birthday) <u>86</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WIDOWED</u>		11. BIRTHPLACE (State or foreign country) <u>9</u>	

13a. FATHER'S NAME <u>CALVIN CROW</u>		13b. MOTHER'S MAIDEN NAME <u>EUNICE SIDWELL</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN M. LIMBRICK (DECEASED)</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>ALICE MAUDE HAYDEN-FOLIA, MO</u>	
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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) <u>Chronic myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 months</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.			
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19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) <u>4222</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 Aug 1st, 1950, to Oct 20th, 1951, that I last saw the deceased alive on Oct 20th, 1951, and that death occurred at 2:30 P. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James B. Bragg, M.D.</u>		23b. ADDRESS <u>Bowling Green, Missouri</u>		23c. DATE SIGNED <u>10/22/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Oct 22, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETERY</u>	
				24d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE, MO.</u>	

DATE REC'D BY LOCAL REG. <u>10/25/51</u>		REGISTRAR'S SIGNATURE <u>Bill Robinson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HALEY MORTUARY, LOUISIANA, MO.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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Date Received: NOV 2 1951
DISTRICT HEALTH OFFICE #
District File Number 10-51-
Date Filed: NOV 2 1951

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 *George M. Collier*

Licensed Embalmer No. *3839*

P. O. Address *Louisiana, M*

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.