

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

6989

State File No.

FILED FEB 19 1952

BIRTH NO. _____		REG. DIST. NO. <u>336</u>		PRIMARY REG. DIST. NO. <u>6129</u>		Registrar's No. <u>160</u>	
1. PLACE OF DEATH a. COUNTY <u>Shannon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Ink Mo</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Ink Mo 1010</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>Ink Mo</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print), a. (First) <u>Martha</u> b. (Middle) <u>Jane</u> c. (Last) <u>Church</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 8 1952</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>April 15 1874</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Sam Thorington</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Neal Williams Ink Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Apoplexy</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Age & Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pneumonia 10 days prior</u>				INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>334.X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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>Jan 27, 1952</u> , to <u>2-8-1952</u> , that I last saw the deceased alive on <u>2-7-1952</u> , and that death occurred at <u>7:45pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Charles F. Wilson M.D.</u>				23b. ADDRESS <u>Eminence Mo</u>		23c. DATE SIGNED <u>2-12-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY <u>Chrisco</u>		24d. LOCATION (City, town, or county) (State) <u>Summersville Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-15-52</u>		REGISTRAR'S SIGNATURE <u>Mabel Ouellet</u>		447		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>None -</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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 _____

Not embalmed by substitute
working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

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.