

No. 300-
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7856**

BIRTH NO. _____ REG. DIST. NO. **87** PRIMARY REG. DIST. NO. **4565** Registrar's No. **3**

1. PLACE OF DEATH a. COUNTY CRAWFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CRAWFORD	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SULLIVAN		c. LENGTH OF STAY (in this place) 25	
d. FULL NAME OF HOSPITAL OR INSTITUTION HOME		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SULLIVAN 0281	
		d. STREET ADDRESS (If rural, give location) 437 S. OLIVE	

3. NAME OF DECEASED (Type or Print)	a. (First) MARU ANNA	b. (Middle) PINSON	c. (Last) HILL	4. DATE OF DEATH (Month) (Day) (Year) MARCH 2 1952
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5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 1	8. DATE OF BIRTH DEC. 17, 1967	9. AGE (In years last birthday) 84	10. UNDER 1 YEAR 3	11. UNDER 24 HRS. 76
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) ANTHONIES MILL, MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME JOSEPH A. PINSON	13b. MOTHER'S MAIDEN NAME MINERVA V. CLOVER	14. NAME OF HUSBAND OR WIFE FRED HILL
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME FRED Hill	ADDRESS SULLIVAN MO
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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		INTERVAL BETWEEN ONSET AND DEATH 6 mo years years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Serility		
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 4500	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) -	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb 7, 1952** to **March 2, 1952**, that I last saw the deceased alive on **March 2, 1952**, and that death occurred at **9 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. F. Amberson, M.D.	23b. ADDRESS Sullivan Mo	23c. DATE SIGNED 2/3/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAR 5, 1952	24c. NAME OF CEMETERY OR CREMATORY SWAN CEMETERY	24d. LOCATION (City, town, or county) (State) ANTHONIES MILL MO
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DATE REC'D BY LOCAL REG. 3/4/52	REGISTRAR'S SIGNATURE Ed Long 75	25. FUNERAL DIRECTOR'S SIGNATURE Ameaton	ADDRESS SULLIVAN MO
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(Licensed Embalmer's Statement on Reverse Side)

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

281
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FILED MAR 25 1952

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 Edgar W. Laffoon
Licensed Embalmer No. 3394

P. O. Address Hullman 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.