

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9062**

FILED APR 8 1952

BIRTH NO. _____ REG. DIST. NO. **200** PRIMARY REG. DIST. NO. **5775** Registrar's No. **36**

1. PLACE OF DEATH a. COUNTY Madison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Knox	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Hudson Twp. 10m		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Edina, Missouri	
d. FULL NAME OF HOSPITAL OR INSTITUTION L. H. O. S.		d. STREET ADDRESS (If rural, give location) 0520	

3. NAME OF DECEASED (Type or Print)	a. (First) Emma	b. (Middle) B	c. (Last) Rimer	4. DATE OF DEATH (Month) (Day) (Year) 3 / 2 / 1952
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W. V	8. DATE OF BIRTH Aug. 29, 1878	9. AGE (In years last birthday) 72	10. UNDER 1 YEAR Months	11. UNDER 1 HRS. Days	12. UNDER 15 Mins.
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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	11. BIRTH PLACE (State or foreign country) Knox Co. Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Wm B Price	13b. MOTHER'S MAIDEN NAME Helen Smith	14. NAME OF HUSBAND OR WIFE Frank Rimer
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓	16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME Dr. M. Mulheir, L. H. O. S.	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Heart 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)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic melancholia			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 4500 YES <input type="checkbox"/> NO <input 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	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 **3/2/52**, 1952, to **3/2**, 1952, that I last saw the deceased alive on **3/2**, 1952, and that death occurred at **2:40P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. M. Mulheir, D.O.	23b. ADDRESS L. H. O. S.	23c. DATE SIGNED 3/2/52
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24a. BURIAL, CREMATION, OR DISPOSAL	24b. DATE March 5-52	24c. NAME OF CEMETERY OR CREMATORY McCarnel	24d. LOCATION (City, town, or county) (State) Knox Co. Missouri
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DATE REC'D BY LOCAL REG 3/27/52	REGISTRAR'S SIGNATURE Ruth Mcneely	185	25. FUNERAL DIRECTOR'S SIGNATURE Keith Hudson	ADDRESS Edina, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
MACON COUNTY HEALTH DEPARTMENT
4. 4. 52
County File No. 4. 52. 6. 3
Date Filed 4. 5. 52

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 Keith Hudson

Licensed Embalmer No. 2415

P. O. Address Edina, Minnesota

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.