

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11447

State File No.

FILED APR 8 1952

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 874

1. PLACE OF DEATH
a. COUNTY ST. LOUIS

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO. b. COUNTY BOLLINGER

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN
RURAL

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN
RURAL CROOKED CREEK TWP.

d. FULL NAME OF HOSPITAL OR INSTITUTION
ROBERTSON MO. ROUTE #2

d. STREET ADDRESS (If rural, give location)
NEAR MAYFIELD 0090

3. NAME OF DECEASED (Type or Print)
a. (First) ANNA b. (Middle) CATHERINE c. (Last) LIMBAUGH

4. DATE OF DEATH (Month) (Day) (Year)
3-29-52

5. SEX
F

6. COLOR OR RACE
W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH
12-12-1892

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.
69 3 17

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HWY.

10b. KIND OF BUSINESS OR INDUSTRY
-

11. BIRTHPLACE (State or foreign country)
BOLLINGER Co. MO.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13a. FATHER'S NAME
COLLINS RIDINGS

13b. MOTHER'S MAIDEN NAME
LYDIA B. WHITE

14. NAME OF HUSBAND OR WIFE
DECEASED

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 ADDRESS
ARVEL S. LIMBAUGH 1615 W. ACE CAPE GIRARDEAU, 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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio-renal
ANTECEDENT CAUSES DUE TO (b) vascular disease
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) 447X
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arthritis Rheumatoid

INTERVAL BETWEEN ONSET AND DEATH
4 yrs
15 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO

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)

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 July, 1951, to Mar 29, 1952, that I last saw the deceased alive on Mar 29, 1952, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
Dr. Leabaugh

23b. ADDRESS
W.D. Webster Groves Mo

23c. DATE SIGNED
4-1-52

24a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

24b. DATE
3-31-52

24c. NAME OF CEMETERY OR CREMATORY
HURRICANE FORK

24d. LOCATION (City, town, or county) (State)
NEAR BESSVILLE MO

DATE REC'D BY LOCAL REG.
4-1-52

REGISTRAR'S SIGNATURE
Herbert R. Donke MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
BAKER FUNERAL HOME BATESVILLE, MO.

SW Licensed Embalmer's Statement on Reverse Side

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

No. 300
10.48

1000

APR 21 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.

Signed _____

J. E. Goshaw

Signed _____
Student Embalmer

Licensed Embalmer No. 4010

P. O. Address Luttwally, 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.