

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37555**

FILED NOV 18 1952

BIRTH NO. _____ REG. DIST. NO. **4** PRIMARY REG. DIST. NO. **4012** Registrar's No. **87**

1. PLACE OF DEATH a. COUNTY Atchison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Atchison	
b. CITY OR TOWN Rock-Port mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rock-Port mo 0230	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0	
3. NAME OF DECEASED a. (First) Ruby b. (Middle) Helen c. (Last) Kellogg			4. DATE OF DEATH (Month) (Day) (Year) Nov 4 - 1952
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July-12-1898
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months 3 Days 2	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) house-wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U
13a. FATHER'S NAME Albert Leroy Perry		13b. MOTHER'S MAIDEN NAME Mary Alice Wood	14. NAME OF HUSBAND OR WIFE Aaron Kellogg
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Aaron Kellogg ADDRESS Rock-Port 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) Metastatic carcinoma of colon, INTERVAL BETWEEN ONSET AND DEATH 1Yr ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ##### 20Yrs DUE TO (c) Carcinoma of both breasts 3 Yrs ii. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arthritis defomans 20 Yrs	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	170x
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 10/4/1952 to 10/4/1952 , that I last saw the deceased alive on 10/4/1952 , and that death occurred at 12/10P , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) L. A. Reitter M.D.		23b. ADDRESS Rockport, Mo.	23c. DATE SIGNED 10/5/52
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Nov-6-1952	24c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	24d. LOCATION (City, town, or county) (State) Rock-Port mo
DATE REC'D BY LOCAL REG. Nov 14, 1952	REGISTRAR'S SIGNATURE Marvin N. Schaefer	443-0	25. FUNERAL DIRECTOR'S SIGNATURE Funeral Home Rock Port Mo ADDRESS

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

030
1

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 _____

C. E. Bertram

Student Embalmer No. _____

working under my personal supervision.

Signed *C. E. Bertram*

Signed _____
Student Embalmer

Licensed Embalmer No. *1764*

P. O. Address *Rock Point MS*

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.