

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39402

No. 300  
10.48

5694 State File No. 3040 Registrar's No. 167

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040

596

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

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-Chillicothe Twp.</b>		c. LENGTH OF STAY (In this place) <b>23 yrs</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>RFD 5 Chillicothe</b>		d. STREET ADDRESS (If rural, give location) <b>RFD 5 Chillicothe, Mo.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Sarah</b> b. (Middle) <b>Elizabeth</b> c. (Last) <b>Steel</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 2, 1952</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		8. DATE OF BIRTH <b>Nov. 14, 1859</b>	
				9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <b>93</b>	
				11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>James Sneary</b>		13b. MOTHER'S MAIDEN NAME <b>Mahaley Harmon</b>		14. NAME OF HUSBAND OR WIFE <b>XX</b>	
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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) <b>No</b>		16. SOCIAL SECURITY NO. <b>XX</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Setlla Kriner, Chillicothe, Mo.</b>	
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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, asthma, 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) <b>Cerebral hemorrhage</b>		DUE TO (b) <b>Arteriosclerosis</b>				<b>2 hrs</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)				<b>long</b>	
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 <b>331X</b>				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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **Dec 2, 1952** to **Dec 2, 1952**, that I last saw the deceased alive on **Dec 2, 1952**, and that death occurred at **7:45 P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Name or title) <b>J. M. Russell M.D.</b>		23b. ADDRESS <b>Chillicothe Mo.</b>		23c. DATE SIGNED <b>Dec 3, 52</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Dec. 5, 1952</b>		24c. NAME OF CEMETERY OR CREMATORY <b>May cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Livingston Co., Mo.</b>	
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DATE REC'D BY LOCAL REG. <b>Dec 13/52</b>		REGISTRAR'S SIGNATURE <b>Frances B Neill</b>		5. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Charles E. ... Chillicothe Mo.</b>	
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**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 David J. New

Licensed Embalmer No. 491

P. O. Address Chillicothe 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.