

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5217

State File No.

FILED FEB 24 1953

BIRTH NO. REG. DIST. NO. 75 PRIMARY REG. DIST. NO. 3015 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>CLINTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>DEKALB.</u>	
b. CITY OR TOWN <u>CAMERON</u>		c. CITY OR TOWN <u>RURAL GRAND</u>	
c. LENGTH OF STAY (In this place)		0320	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CAMERON HOSPITAL</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) <u>Audley Eageron Quisenberry</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 12 1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>JUNE 27 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>MA STERLING - Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	

13a. FATHER'S NAME <u>MARTIN Quisenberry</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Moore</u>	14. NAME OF HUSBAND OR WIFE <u>Gertrude deceased</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. John Dice Cameron. MO</u>

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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Influenza</u> DUE TO (c) 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>481X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 ml</u>	
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)
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

22. I hereby certify that I attended the deceased from 2-11, 1953 to 2-12, 1953, that I last saw the deceased alive on 2-12, 1953, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Ed Kinner MD</u>	(Degree or title)	23b. ADDRESS <u>Cameron Mo</u>	23c. DATE SIGNED <u>2-13-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>2-14-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Christian Chapel</u>	24d. LOCATION (City, town, or county) (State) <u>DEKALB CO MO</u>
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DATE REC'D BY LOCAL REG. <u>2-16-53</u>	REGISTRAR'S SIGNATURE <u>Winifred W. Moser</u>	370-025 FUNERAL DIRECTOR'S SIGNATURE <u>DeMoss</u>	ADDRESS <u>CRUNK CAMERON. MO</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Lee M. Shunk

Licensed Embalmer No. *2533*

P. O. Address *Cameron 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.