

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED AUG 10 1953

BIRTH NO. _____ REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **3072** Registrar's No. **157**

972
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall, Mo.	
c. LENGTH OF STAY (in this place) 2 Weeks		d. STREET ADDRESS (If rural, give location) 412 North Lafayette	
d. FULL NAME OF HOSPITAL OR INSTITUTION Marshall Rest Home			

3. NAME OF DECEASED (Type or Print)	a. (First) Rosetta	b. (Middle) Minks	c. (Last) Herndon	4. DATE OF DEATH (Month) (Day) (Year) Aug. 3 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 4-1878	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months 5 Days 11	IF UNDER 24 Hrs. Hours 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 Own Home	11. BIRTHPLACE (City and State or Foreign Country) Salisbury, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Minks	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE - - -
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Virgil Land-Marshall	ADDRESS Miaaouri
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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 14 1/2
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterial Sclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pheneston Arthritis		124	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4500	20. AUTOPSY 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)
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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?
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22. I hereby certify that I attended the deceased from **Nov 19 52 Aug 3 1953**, 19**53**, that I last saw the deceased alive on **Aug 3 1953**, and that death occurred at **11:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)	23b. ADDRESS [Address]	23c. DATE SIGNED 8/4/53
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24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 8/6/53	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	24d. LOCATION (City, town, or county) (State) 6 miles south of Marshall, Mo.
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DATE REC'D BY LOCAL REG. Aug 4-1953	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS [Address]
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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 J. Leslie Sweeney

Licensed Embalmer No. 3235

P. O. Address Marshall, 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.