

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 20 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **360** PRIMARY REG. DIST. NO. **6225** Registrar's No. **173**

1080

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

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Marshall Wash Hwy</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Marshall 0972</b>	
c. LENGTH OF STAY (In this place) <b>51-6-19</b>		d. STREET ADDRESS (If rural, give location) <b>Unknown</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State Hospital #3-Nevada, Mo</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Rinie E.</b> b. (Middle) <b>Allison</b> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <b>10-8-53</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED/NEVER MARRIED, WIDOWER/DIVORCED (Specify) <b>Wid</b>	8. DATE OF BIRTH <b>12-11-65</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR (Month) (Day) (Year) _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Marshall Mo</b>	
12a. FATHER'S NAME <b>David Cochran</b>		12b. MOTHER'S MAIDEN NAME <b>Sarah Pierce</b>		12c. NAME OF HUSBAND OR WIFE <b>Widow</b>	

13a. FATHER'S NAME <b>David Cochran</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Pierce</b>		14. NAME OF HUSBAND OR WIFE <b>Widow</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch or date of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE AND NAME ADDRESS <b>Hospital records</b>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Thyocorditis</b>		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Fracture right femur</b>		<b>10-2-53</b>	

19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION <b>None</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hospital Bed</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Nevada Vernon MO</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>10-2-53 9 p.m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Fell getting out of bed</b>	

22. I hereby certify that I attended the deceased from **1-13**, 19**52**, to **10-8**, 19**53**, that I last saw the deceased alive on **10-8**, 19**53**, and that death occurred at **9 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>R. G. Hall Mo</b>		23b. ADDRESS <b>Nevada Mo</b>		23c. DATE SIGNED <b>10-8-53</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10/9/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Griggs Park Cemetery Marshall, Mo</b>	
24d. LOCATION (City, town, or county) (State) <b>Marshall, Mo</b>		24e. NAME OF CEMETERY OR CREMATORY <b>Griggs Park Cemetery Marshall, Mo</b>		24f. LOCATION (City, town, or county) (State) <b>Marshall, Mo</b>	

DATE REC'D BY LOCAL REG. <b>10-17-53</b>		REGISTRAR'S SIGNATURE <b>Anna E. Ferry</b>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Campbell Lewis H. Marshall, 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 \_\_\_\_\_

Licensed Embalmer No. 26576

P. O. Address Nevada 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.