

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____ 30

FILED JAN 18 1954

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>30</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>DeKalb</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Joseph</u>		c. LENGTH OF STAY (in this place) <u>3</u> <u>MO</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clarksdale</u> <u>0.320</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home, 1407 Mitchell Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Harriett</u>			b. (Middle) <u>Ann</u>		c. (Last) <u>Babbitt</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 9 54</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>WIDOW</u>		8. DATE OF BIRTH <u>Jan, 4, 1873</u>		9. AGE (In years less birthday) <u>81</u>	10. INTERVAL BETWEEN BIRTH AND DEATH Months _____ Days _____ Hours _____ Mins _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jacob Shepard</u>			13b. MOTHER'S MAIDEN NAME <u>Harriet Combes</u>		14. NAME OF HUSBAND OR WIFE <u>Almon Babbitt</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Mrs Ralph Milligan 1407 Mitchell Ave</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cerebral Accident</u> ANTECEDENT CAUSES DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Serubity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u> <u>?</u> <u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>				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)		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 <u>12-8-1953</u> to <u>1-9-1954</u> that I last saw the deceased alive on <u>1-8-1954</u> , and that death occurred at <u>9:00P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Type or Print) <u>R. W. Kiehl, M.D.</u>				23b. ADDRESS <u>St. Joseph, Mo</u>		23c. DATE SIGNED <u>1-2-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-12-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Prospect Grove</u>		24d. LOCATION (City, town, or county) (State) <u>Stewartville Mo</u>	
DATE REC'D BY LOCAL REG. <u>Jan 14, 1954</u>		REGISTRAR'S SIGNATURE <u>Esther M. Allison</u>		GENERAL DIRECTOR'S SIGNATURE <u>John Brown</u>		ADDRESS <u>Maysville Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

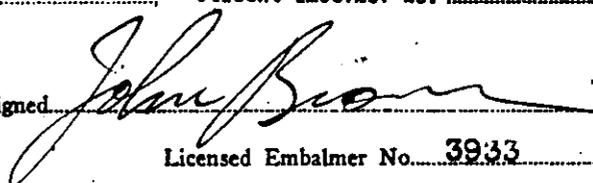
STATEMENT BY LICENSED EMBALMER

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  _____

Licensed Embalmer No. 3933

P. O. Address Mayeville 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.