

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 2 1954

BIRTH NO. _____ REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 6290 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>DALLAS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BUFFALO MO</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BUFFALO R.R. 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>S. Benton</u>		d. STREET ADDRESS (If rural, give location) <u>0300</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Jessie</u> b. (Middle) _____ c. (Last) <u>SHINN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1-25-1954</u>		
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5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>12-24-1869</u>		9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 1 HR. Hours Min.	
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10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crocker Keeper</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>Iowa</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
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13a. FATHER'S NAME <u>James Winslow</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Marquard</u>			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) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Walter Shrick</u> ADDRESS <u>WDRR</u>			
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Terminal Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral hemorrhage</u> <u>5 days</u> DUE TO (c) <u>Arterio Sclerosis & Hypertension</u> <u>10 years</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral hemorrhage 3 yrs ago</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u> <u>10 years</u>	
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19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						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) _____		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 Jan 20, 1954, to Jan 25, 1954, that I last saw the deceased alive on Jan 20, 1954, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>G. L. Plummer M.D.</u>		23b. ADDRESS <u>Buffalo Mo</u>		23c. DATE SIGNED <u>1-26-54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-29-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>West Union</u>		24d. LOCATION (City, town, or county) (State) <u>Sargent Neb.</u>	
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DATE REC'D BY LOCAL REG. <u>1-28-54</u>		REGISTRAR'S SIGNATURE <u>Grace Peterson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. B. Jones</u> ADDRESS <u>Buffalo 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 Miss B Jones

Licensed Embalmer No. 7323

P. O. Address Buffalo, 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.