No. 300
10.48

FILED JAN 4 1955

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40095

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 360

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

1. PLACE OF DEATH
a. COUNTY: Boone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Columbia
c. LENGTH OF STAY (in this place): 5 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boone Co. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Boone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashland, 0100
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Annie
b. (Middle): B
c. (Last): Atkins

4. DATE OF DEATH (Month) (Day) (Year): Dec 28 1954

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April-9-1868
9. AGE (In years last birthday): 86 — If under 1 year: Months 8, Days 19 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ✓
11. BIRTHPLACE (City and State or Foreign Country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Wm W. Hall
13b. MOTHER'S MAIDEN NAME: Irene Griffin
14. NAME OF HUSBAND OR WIFE: James Atkins

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 / ADDRESS: Roger Hall - Ashland, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown

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.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 4200
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-24, 1954, *to* 12-28, 1954, *that I last saw the deceased alive on* 12-28-54 19__, *and that death occurred at* 9P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Roland P. Ladenson MD
23b. ADDRESS: Columbia, Mo
23c. DATE SIGNED: 12-28-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 31-1954
24c. NAME OF CEMETERY OR CREMATORY: New Salem Cemt.
24d. LOCATION (City, town, or county) (State): Ashland, Mo.

DATE REC'D BY LOCAL REG.: Dec 31 1954
REGISTRAR'S SIGNATURE: Mrs R E Palmer 31-0
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Wm L Burnett Ashland Mo

(Licensed Embalmer's Statement on Reverse Side)

APR 29 1957

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 Wm C. Burnett

Licensed Embalmer No. 3564

P. O. Address Ashland 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.