

FILED JAN 19 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **121**

BIRTH NO. _____		REG. DIST. NO. <b>27</b>		PRIMARY REG. DIST. NO. <b>0096</b>		Registrar's No. <b>7</b>	
1. PLACE OF DEATH a. COUNTY <b>Bates</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bates</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Butler</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) <b>Rural-Spruce Two.</b>		<b>0070</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Pine Tree Rest Home</b>				d. STREET ADDRESS (If rural, give location) <b>0</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b>			b. (Middle) <b>S</b>		c. (Last) <b>McAninch</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Jan 12 1955</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>Feb. 22, 1861</b>	
9. AGE (In years last birthday) <b>95</b>		IF UNDER 1 YEAR Month <b>10</b> Day <b>23</b>		IF UNDER 100 YRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Johnstown Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Samuel McAninch</b>			13b. MOTHER'S MAIDEN NAME <b>Not Known</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>C.L. Cantrell, Adrian Mo.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Rest.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>age</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 <b>4201</b>					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 <b>Jan. 9, 1955</b> , to <b>Jan. 9, 1955</b> , that I last saw the deceased alive on <b>Jan. 9, 1955</b> , and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>R. E. Robinson M.D.</b>				23b. ADDRESS <b>Adrian, Mo.</b>		23c. DATE SIGNED <b>Jan. 12-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>1-14-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Double Branch Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Bates Co. Mo.</b>		
DATE REC'D BY LOCAL REG. <b>Jan. 12-55</b>		REGISTRAR'S SIGNATURE <b>Randall Kering 17-0</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>Liz Funeral Soc Adrian Mo</b>		

(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 Robert G. Steinbeck

Licensed Embalmer No. 4657

P. O. Address Butler, 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.