

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7567**

FILED APR 15 1955

BIRTH NO.		REG. DIST. NO. 65	PRIMARY REG. DIST. NO. 5259	Registrar's No. 15
1. PLACE OF DEATH a. COUNTY Chariton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Chariton		
b. CITY (If outside corporate limits, write RURAL and give township) Snyder	c. LENGTH OF STAY (If this place) 3 days	c. CITY OR TOWN Triphett	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) Amanda Jane b. (Middle) Riddell c. (Last) Riddell		4. DATE OF DEATH (Month) (Day) (Year) April 11 - 1955		
5. SEX F.	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH JAN. 25 - 1862	9. AGE (In years last birthday) Months Day Year If UNDER 4 HRS. Hours Min. 93 2 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (City and State or Foreign Country) Winchester Illinois	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME George Muckey		13b. MOTHER'S MAIDEN NAME Margaret Johnson	14. NAME OF HUSBAND OR WIFE Wm. Riddell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Glyde Muckey Triphett 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) LEFT VENTRULAR INSUFFICIENCY ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) MITRAL REGURGITATION DUE TO (c) CHRONIC ENDOCARDITIS		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS 3 MONTHS 20 YEARS
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) 410X	
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 JAN. 10, 1955 , to APRIL 11, 1955 , that I last saw the deceased alive on APRIL 3, 1955 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above.				
23a. SIGNATURE Kenneth L. Rozinsanski DO		23b. ADDRESS TRIPLETT MO		23c. DATE SIGNED 4-12-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/13/55	24c. NAME OF CEMETERY OR CREMATORY New Comer	24d. LOCATION (City, town, or county) (State) Menden Mo R.F.D.	
DATE REC'D BY LOCAL REG. 4-13-55		REGISTRAR'S SIGNATURE Mildred Bruce	56-0 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. A. Shepard Menden Mo	

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, ~~as~~-by, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *A. D. Lipard*

Licensed Embalmer No. *397*

P. O. Address *Mendon*

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.