THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

19544

State File No. .....

BIRTH NO. FILED JUL 5 - 1955 REG. DIST. NO. 251 PRIMARY REG. DIST. NO. 5857 Registrar's No. 174

1. PLACE OF DEATH
a. COUNTY Nodaway
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Independence
c. LENGTH OF STAY (in this place) 1 ½ Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

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

1130

3. NAME OF DECEASED (Type or Print)
a. (First) Ida
b. (Middle) Leona
c. (Last) Rickabaugh

4. DATE OF DEATH (Month) (Day) (Year) June 23, 1955

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH October 25, 1877
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

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

13a. FATHER'S NAME George W. Beauchamp
13b. MOTHER'S MAIDEN NAME Sarah E. Thomas
14. NAME OF HUSBAND OR WIFE David Porter Rickabaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Mrs. Viva M. Gabbert - Sheridan, Mo. ADDRESS

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) Medullary failure — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Cerebrovascular accident — 3 days
DUE TO (c) Hypertensive Arteriosclerosis — year

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
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* Jan 3, 1955, *to* June 19, 1955, *that I last saw the deceased alive on* June 19, 1955, *and that death occurred at* 4:45 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Richard J. Smith DO
23b. ADDRESS Grant City, Mo.
23c. DATE SIGNED 6-23-55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-25-1955
24c. NAME OF CEMETERY OR CREMATORY Sheridan Cemetery
24d. LOCATION (City, town, or county) (State) Sheridan, Missouri

DATE REC'D BY LOCAL REG. 7-2-55
REGISTRAR'S SIGNATURE Bess Holt 229
25. FUNERAL DIRECTOR'S SIGNATURE Bill Dunfee - Grant City, Mo. ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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 Bill A. Dunf

Licensed Embalmer No. 4908

P. O. Address Grand City, N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

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