

FILED OCT 24 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **33024**

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>87</u>			
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u>				b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>			c. LENGTH OF STAY (in this place) <u>2 months</u>		c. CITY OR TOWN <u>Mountain View</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION				e. STREET ADDRESS (If rural, give location) <u>04600</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>DORA</u>			b. (Middle) <u>LUELLA</u>		c. (Last) <u>MINER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 30-1955</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, (a) WIDOWED, (b) DIVORCED (Specify) <u>W</u>		8. DATE OF BIRTH <u>July 10-1876</u>		9. AGE (In years last birthday) <u>79</u>	
						IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u>		IF UNDER 2 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Dent, County Missouri</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>Shelvey Chrisco</u>			13b. MOTHER'S MAIDEN NAME <u>Josephine Rich</u>			14. NAME OF HUSBAND OR WIFE			
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 <u>Roscoe Miner Warsaw, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>							
		ANTECEDENT CAUSES DUE TO (b) <u>Senile Insanity</u>							
		DUE TO (c)							
		II. OTHER SIGNIFICANT CONDITIONS <u>331X</u>							
		Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min)		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 <u>Aug 16, 1955</u> , to <u>Sept 30, 1955</u> , that I last saw the deceased alive on <u>Sept 30, 1955</u> , and that death occurred at <u>7 P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>Dr. Richard A. Smith</u> (Degree or title) <u>D.O.</u>				23b. ADDRESS <u>917 W. Main, West Plains, Mo.</u>				23c. DATE SIGNED <u>10-7-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>Oct. 3-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City</u>		24d. LOCATION (City, town, or county) (State) <u>Mountain View, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>10-20-55</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> <sup>379</sup>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Duncans Mtn View, Mo.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed *Joe R. Duncan*.....  
Licensed Embalmer No. *430*.....

P. O. Address *Mtn. View*.....

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.