

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 13 1955

State File No. **36410**

BIRTH NO. _____ REG. DIST. NO. **101** PRIMARY REG. DIST. NO. **5399** Registrar's No. **61**

1. PLACE OF DEATH a. COUNTY Douglas		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Douglas	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Renne Campbell		c. CITY OR TOWN Renne	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) Campbell	

3. NAME OF DECEASED (Type or Print) a. (First) Annie P. b. (Middle) Single c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Dec. 2, 1955		
5. SEX F M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH Feb. 2, 1891		9. AGE (To years last birthday) 74		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (City and State or Foreign Country) Alturas, Penn	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Amos Hamaker		13b. MOTHER'S MAIDEN NAME Rebecca Kinsley	
14. NAME OF HUSBAND OR WIFE Robert Single		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. None	

17. INFORMANT'S SIGNATURE OR NAME Mrs. Ishauer Blakey-Renne		18. ADDRESS Mo.	
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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) Acute Myocarditis		II. OTHER SIGNIFICANT CONDITIONS			
*This does not mean the mode of dying, such as heart failure, asthenia, 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)			
		DUE TO (c)			
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)	
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 **9-2, 1955**, to **12-2, 1955**, that I last saw the deceased alive on **12-2, 1955**, and that death occurred at **3:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. C. P. Hecker D.O.		23b. ADDRESS Mo.		23c. DATE SIGNED 12-7-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-5-55		24c. NAME OF CEMETERY OR CREMATORY Spring Creek	
24d. LOCATION (City, town, or county) (State) Smalltown Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Chinkingheard		ADDRESS Funeral Home	
DATE REC'D BY LOCAL REG. 12-9-55		REGISTRAR'S SIGNATURE Uestal Bushman		94-0	

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

0.300
0.48

0340

0370

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 *Charles R. Fish*.....

Licensed Embalmer No. *466*.....

P. O. Address *Avon, Mass.*.....

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.