

FILED NOV 30 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39498**

BIRTH NO. _____		REG. DIST. NO. <b>366</b>		PRIMARY REG. DIST. NO. <b>6241</b>		Registrar's No. <b>77</b>	
1. PLACE OF DEATH a. COUNTY <b>Washington</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before death.) a. STATE <b>Missouri</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN <b>Rural - Britton</b>		c. LENGTH OF STAY (in this place) <b>8 Years</b>		c. CITY OR TOWN <b>Rural</b>		d. 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 <b>Near Frank Clay</b>				e. STREET ADDRESS (If rural, give location) <b>Near Frank Clay</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Minnie</b>		b. (Middle) <b>E.</b>		c. (Last) <b>Rabonson</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 23 1955</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>July 12 1884</b>	
9. AGE (In years last birthday) <b>71</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		11. BIRTH PLACE (City and State or Foreign Country) <b>Washington Co. Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Simmons</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Andrew Rabonson St. Louis Mo</b> 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pneumonia following Diabetes of 2 years standing</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>260X</b>				INTERVAL BETWEEN ONSET AND DEATH _____	
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) _____		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>June</b> , 19 <b>54</b> , to <b>July 12</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Nov 20</b> , 19 <b>55</b> , and that death occurred at <b>8:10 A.M.</b> from the causes and on the date stated above.							
23a. SIGNATURE <b>H. F. Greenwell M.D.</b> (Degree or title)				23b. ADDRESS <b>Patoni Mo</b>		23c. DATE SIGNED <b>11/28/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>11-25-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Hilson Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Francis Co. Mo</b>	
DATE REC'D BY LOCAL REG. <b>11/28/55</b>		REGISTRAR'S SIGNATURE <b>H. F. Greenwell</b> <b>403-0</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Luther Spahr Patoni Mo</b> ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

NOV 29 1955

WASH. COUNTY HEALTH DEPT.

File No. \_\_\_\_\_

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 *Murphy & Sparks*  
Licensed Embalmer No. *4536*

P. O. Address *Flat River 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.