

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41268**

FILED DEC 19 1955

BIRTH NO. _____ REG. DIST. NO. **184** PRIMARY REG. DIST. NO. **3038** Registrar's No. **587**

1. PLACE OF DEATH a. COUNTY hinn			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Chariton		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Brookfield		c. LENGTH OF STAY (in this place) 1 day	c. CITY OR TOWN Snyder		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 Doctors Hospital			e. STREET ADDRESS (If rural, give location) 2210,		
3. NAME OF DECEASED (Type or Print) a. (First) Carol Elizabeth b. (Middle) Channing c. (Last) Channing			4. DATE OF DEATH (Month) (Day) (Year) 12-10-1955		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 16-1954		9. AGE (In years last birthday) 1 if under 1 year 4 Days 24 Hours 18 Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAER		10b. KIND OF BUSINESS OR INDUSTRY ✓	11. BIRTHPLACE (City and State or Foreign Country) Lexington MO		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Donald Paul Channing		13b. MOTHER'S MAIDEN NAME Josephene Mark		14. NAME OF HUSBAND OR WIFE ✓	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ✓		17. INFORMANT'S SIGNATURE OR NAME Mrs Donald Channing Snyder ADDRESS 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) Bronchial pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute Bronchitis. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 500x		
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) m.		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 Dec 9, 1955 , to Dec 10, 1955 , that I last saw the deceased alive on Dec 10, 1955 , and that death occurred at 7 p.m. , from the causes and on the date stated above.					
23a. SIGNATURE H. Fowler MD (Degree or title)			23b. ADDRESS Brunswick MO		23c. DATE SIGNED 12-10-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/12/55	24c. NAME OF CEMETERY OR CREMATORY Wharton		24d. LOCATION (City, town, or county) (State) Bosworth MO
DATE REC'D BY LOCAL REG. 12-13-55		REGISTRAR'S SIGNATURE Katharine Johnson		25. FUNERAL DIRECTOR'S SIGNATURE D. A. Reissard ADDRESS Mendon MO	

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

MAY 15 1936

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, ~~or~~ by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
S. P. Ripard

Licensed Embalmer No. 39

P. O. Address *Wend*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.