

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3561

STATE FILE NUMBER

FILED JAN 21 1957

Registration District No. 378 Primary Registration District No. 4552 Registrar's No. 2

Health,  
Welfare  
Public  
Service

300  
7-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be treated.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Wright</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Douglas</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mtn. Grove</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Cuba</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Stewart Rest Home</u>			Length of stay in 1b <u>3 days</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Winnie</u> Middle <u></u> Last <u>Chinkinghead</u>				4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March - 21 - 1883</u>		9. AGE (In years last birthday) <u>73</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Cuba - Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Chinkinghead</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Ellison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Clarence Chinkinghead - Cuba Mo. R. 1.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>331X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Jan 3 - 1957</u> , to <u>Jan 6 - 1957</u> and last saw her <sup>her</sup> <del>him</del> alive on <u>1-6-57</u> Death occurred at <u>3:25 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>W. W. Clenny M.D.</u> (Degree or title)				22b. ADDRESS <u>Mtn. Grove Mo.</u>		22c. DATE SIGNED <u>1-7-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1-6-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Burdett's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cuba, Mo. Route 1</u>		
24. FUNERAL DIRECTOR <u>Chinkinghead Funeral Home</u> ADDRESS <u>Cuba, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>1-9-57</u>		26. REGISTRAR'S SIGNATURE <u>A. G. Ames</u>	

RECEIVED 1-15-1959  
WRIGHT CO. HEALTH DEPT.  
County File Number 157-5  
Date Filed 1-19-1959

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. Fisk*.....

Licensed Embalmer No. 46

P. O. Address *Avon, N.*

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