

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 12 1957

STATE FILING NO. **10882**  
**2753**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

Health,  
& Welfare  
Public  
Service

300  
1-56

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

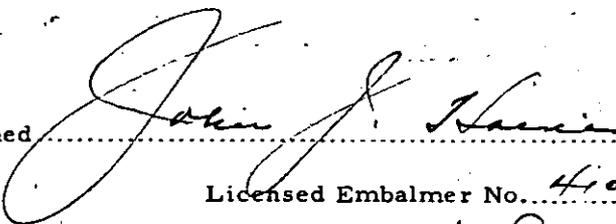
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Indiana</b> b. COUNTY <b>Knox</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Bicknell</b> <b>§ 1308</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b> <b>5 Weeks</b>			d. STREET ADDRESS <b>602 W. Fourth</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CAROLYN</b> Middle <b>JUNE</b> Last <b>PINNICK</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1931</b>		9. AGE (In years last birthday) <b>25</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Bicknell, Ind. /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Orlando C. Pinnick</b>			14. MOTHER'S MAIDEN NAME <b>Mary Clark</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>O.C. Pinnick, Bicknell, Ind.</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILIARY CIRRHOSIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>SEV. YRS.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>GALL BLADDER STONES</b>					
DUE TO (c) <b>584x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>FIBROSIS OF COMMON BILE DUCT</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.					
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 <b>FEB. 9, 1957</b> to <b>MARCH 19, 1957</b> and last saw her alive on <b>MAR. 19, 1957</b> Death occurred at <b>6:00 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>C. Pinnick, M.D.</b>			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>3/20/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3-20-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) (State) <b>Bicknell, Ind.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>MAR 20 '57</b>		26. REGISTRAR'S SIGNATURE <b>J. C. Smith M.D.</b> <i>mjb</i>

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 .....  
Licensed Embalmer No. 410

P. O. Address *to Lawrence*.....

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.