

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 7 1960

-60-025622

Registration District No. 374 Primary Registration District No. 6276 Registrar's No. 210 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Worth		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Worth	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Union Township		Length of stay in 1b 1 week	c. CITY OR TOWN Allendale Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Ollie Middle Rinehart Last Rinehart			4. DATE OF DEATH Month May Day 31 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-7-1880	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Worth County, Mo.	12. CITIZEN OF WHAT COUNTRY U. S.		
13a. FATHER'S NAME Kindel		13b. MOTHER'S MAIDEN NAME Jennie Williams		14. NAME OF HUSBAND OR WIFE Charley K. Rinehart		

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 Mrs. Lois Constant-Sheridan, Missouri	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis, Generalized	5yrs
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	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 **1955** to **May 31, 66** and last saw her ^{her} _{him} alive on **May 30**
Death occurred at **6:30** ^{pm} on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Source) or title Frank B Matteson M D		22b. ADDRESS Grant City, Mo	22c. DATE SIGNED 6/3/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-4-1960	23c. NAME OF CEMETERY OR CREMATORY Allendale, Missouri	23d. LOCATION (City, town, or county) (State) Allendale, Missouri

24. FUNERAL DIRECTOR Bill A. Dungee, Grant City, Mo	ADDRESS	25. DATE RECD. BY LOCAL REG. 7-1-1960	26. REGISTRAR'S SIGNATURE Keta E. Dawson
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Bill A. Jungler

Licensed Embalmer No. 4902

P. O. Address Grant City

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.