

pt. Health,  
S. Public  
Health Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-041390

STATE FILE NUMBER

FILED VS DEC 1 1960

Registration District No. 74 Primary Registration District No. H-136 Registrar's No. 44

S. 300  
ev. 1-57

2.50

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Plattsburg</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Plattsburg</u> <sup>c 2502</sup> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>90 506 Maple St.</u>		Length of stay in 1b <u>2 months</u>	d. STREET ADDRESS (If outside, give location) <u>506 Maple St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie Elizabeth Quinn</u>			4. DATE OF DEATH Month Day Year <u>Nov. 26, 1960</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>xxxxxx</u>	9. AGE (In years last birthday) <u>88</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <u>Gower, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. G.</u>	
13a. FATHER'S NAME <u>John R. Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Belle Weakley</u>	14. NAME OF HUSBAND OR WIFE <u>Robert Quinn</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. James Carter, Plattsburg, Mo.</u>		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) <u>Myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>4222</u> DUE TO (c) <u>4222</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Insanition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>60 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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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>Sept 1-60</u> to <u>Nov 25-60</u> and last saw her/him alive on <u>Nov 24-1960</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (D, M, or title) <u>W B Spalding M.D.</u>		22b. ADDRESS <u>Plattsburg Mo</u>	22c. DATE SIGNED <u>Nov 26-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>11/28/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Plattsburg, Missouri</u>
24. FUNERAL DIRECTOR <u>Swon Funeral Home, Inc, Plattsburg, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-28-1960</u>	26. REGISTRAR'S SIGNATURE <u>Mary W Seearce</u>

MAR 7 1961

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 *Phillip E. Col* .....

Licensed Embalmer No. *4993* .....

P. O. Address *Stamford, CT* .....

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.