

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004791

FILED VS FEB 20 1961

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 4080 Registrar's No. 14

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CARROLL</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>NORBORNE</u>		Length of stay in lb <u>30 yrs</u>		c. CITY OR TOWN <u>NORBORNE</u>		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>304 South Pine</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>304 S. Pine</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>B.</u> Last <u>QUAINTANCE</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>13.</u> Year <u>1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-2-1911</u>		9. AGE (last birthday) <u>49</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
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>at Home</u>		11. BIRTHPLACE (City and state or country) <u>Des Moines, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u>					
13a. FATHER'S NAME <u>Issac Jones</u>				13b. MOTHER'S MAIDEN NAME <u>ANNA KINCAID</u>				14. NAME OF HUSBAND OR WIFE <u>D.E. Quintance</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>304 S. Pine</u> <u>Dr. D.E. Quintance Norborne, Mo.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u>										<u>3 Days.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Pneumonia</u>										<u>9 MO.</u>			
DUE TO (c) <u>Complications -</u>										<u>17 MO.</u>			
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			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. 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 22, 1961</u> to <u>Feb 13, 1961</u> and last saw him alive on <u>Feb 13, 1961</u> . Death occurred at <u>10:40 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Deceased or title) <u>D. E. Kruschel M.D.</u>						22b. ADDRESS <u>Norborne, Mo</u>			22c. DATE SIGNED <u>Feb 15, 1961</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 15, 1961</u>		23c. NAME OF CEMETERY OR CREMATOR <u>FAIRHAVEN Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>NORBORNE, Missouri</u>					
24. FUNERAL DIRECTOR <u>Gibson Funeral Home</u>				ADDRESS <u>Home Norborne, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-13-61</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Herbert Carter</u>					

**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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, Ga.

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.