SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-016147
STATE FILE NUMBER

AMENDED

Registration District No. 336 Primary Registration District No. 4494 Registrar's No. 99

FILED MAY 10 1961

1. PLACE OF DEATH
a. COUNTY Shannon

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Shannon

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Winona — Length of stay in 1b Years

c. CITY OR TOWN Winona — Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Pearl Middle A. Last Hurst

4. DATE OF DEATH Month April Day 23 Year 1961

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH Nov. 17, 1881

9. AGE (last birthday) 80 — 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)

10b. KIND OF BUSINESS OR INDUSTRY Housewife

11. BIRTHPLACE (City and state or country) Peace Valley, Mo.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Taylor Atkins

13b. MOTHER'S MAIDEN NAME Armanda Bandy

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. No.

17. INFORMANT Inez Fagg, Winona, Mo. 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) CHRONIC MYOCARDITIS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) CHRONIC DIFFUSE NEPHRITIS WITH EXUDATION

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Jan 25-61, to April 23 and last saw her alive on 4/23/61

Death occurred at 10 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. D. Rollins M.D.

22b. ADDRESS Winona Mo

22c. DATE SIGNED 5-6-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 4,25,1961

23c. NAME OF CEMETERY OR CREMATORY Mt. Zion, Winona, Mo.

23d. LOCATION (City, town, or county) (State) Winona, Mo.

24. FUNERAL DIRECTOR ADDRESS Duncan Funeral Home, Mtn. View, Mo.

25. DATE RECD. BY LOCAL REG. 5-6-1961

26. REGISTRAR'S SIGNATURE Mabel Rollins

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — BY AFFIDAVIT OF — MEDICAL CERTIFICATION

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_____ Signed Charles D. Partin

Signature of Student Embalmer

Licensed Embalmer No. 5107

P. O. Address Mt View, C

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.