

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-023849**

STATE FILE NUMBER

FILED JUL 31 1961 Primary Registration District No. 3000 Registrar's No. 201

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

|  |  |  |   |   |  |   |  |  |  |  |  |                     |  |
|--|--|--|---|---|--|---|--|--|--|--|--|---------------------|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Adair</u>   |  |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>                        |  |   |  |  |  |  |  |                     |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>  |  | Length of stay in 1b <u>2 weeks</u>  |   | c. CITY OR TOWN <u>Green City</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>Grim-Smith Hospital</u>   |  |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location) <u>No street address</u> |   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |  |  |  |                     |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>Blanche</u> Middle <u>-----</u> Last <u>Kinton</u>   |  |  |   | <b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>17</u> , Year <u>1961</u>  |  |   |  |  |  |  |  |                     |  |
| <b>5. SEX</b> <u>Female</u>  |  | <b>6. COLOR OR RACE</b> <u>White</u>   |   | <b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b> <u>9/17/1896</u>  |  | <b>9. AGE</b> (last birthday) <u>64</u>  |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HR Min. |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  |  |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm home</u>   |  | <b>11. BIRTHPLACE</b> (City and state or country) <u>Sullivan Co. Mo.</u>         |  | <b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>  |  |  |  |                     |  |
| <b>13a. FATHER'S NAME</b> <u>James Landon Miller</u>   |  |  |   | <b>13b. MOTHER'S MAIDEN NAME</b> <u>Minerva Frances See</u>   |  |   |  | <b>14. NAME OF HUSBAND OR WIFE</b> <u>Neal W. Kinton</u>   |  |  |  |                     |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>  |  |  |   | <b>16. SOCIAL SECURITY NO.</b> <u>DON'T KNOW</u>  |  | <b>17. INFORMANT</b> Address <u>Mrs. Edgar Martin, Green City, Mo.</u>            |  |  |  |  |  |                     |  |
| <b>18. CAUSE OF DEATH</b> (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>metastatic carcinoma of liver</u>   |  |  |   |   |  |   |  |  |  | <u>3 weeks</u>                         |  |                     |  |
| DUE TO (b) <u>carcinoma of gall bladder</u>  |  |  |   |   |  |   |  |  |  | <u>9-12 months</u>                     |  |                     |  |
| DUE TO (c) _____   |  |  |   |   |  |   |  |  |  |  |  |                     |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |  |  |   |   |  |   |  |  |  |  |  |                     |  |
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |  |                     |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | <b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/> |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)   |  |   |  |  |  |  |  |                     |  |
| <b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.  |  | Month, Day, Year _____   |   |   |  |   |  |  |  |  |  |                     |  |
| <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                |   | <b>20f. CITY, TOWN, OR LOCATION</b>   |  | COUNTY  |  | STATE  |  |  |  |                     |  |
| <b>21. I attended the deceased from</b> <u>6.29.61</u> to <u>7.17.61</u> and last saw her/him alive on <u>7.17.61</u><br>Death occurred at <u>2:00</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated. |  |  |   |   |  |   |  |  |  |  |  |                     |  |
| <b>22a. SIGNATURE</b> (Degree or title) <u>Wilton T. Engler MA</u>   |  |  |   |   |  | <b>22b. ADDRESS</b> <u>Kirksville Mo</u>  |  |  | <b>22c. DATE SIGNED</b> <u>7.19.61</u> |  |  |                     |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>   |  | <b>23b. DATE</b> <u>July 20, 1961</u>  |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet Cemetery</u>  |  | <b>23d. LOCATION</b> (City) town, or county) <u>Green City, Mo.</u> (State)       |  |  |  |  |  |                     |  |
| <b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Blern E. Kent, Green City, Mo.</u>  |  |  |   | <b>25. DATE RECD. BY LOCAL REG.</b> <u>July 24, 1961</u>  |  | <b>26. REGISTRAR'S SIGNATURE</b> <u>Doris W. Ratliff</u>                          |  |  |  |  |  |                     |  |

AUG 1 1962

MILTON T. ENGLISH, M.D.

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 Carl R. Kent  
Licensed Embalmer No. 4689

P. O. Address Green City, Mo.

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.