

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032194

STATE FILE NUMBER

AMENDED

Registration District No. 70 Primary Registration District No. _____ Registrar's No. 50

FILED OCT 4 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Clark</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Clark</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kahoka</u>		c. CITY OR TOWN <u>Canton, Missouri</u>	
Length of stay in 1b _____		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dr. Watson B Office Kahoka</u>		d. STREET ADDRESS (If outside, give location) <u>R. R. #. 1</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year
<u>Margaret Bainter</u>			<u>Aug. 5, 1961</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>10-10-1891</u>
9. AGE (last birthday) <u>69</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>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>	11. BIRTHPLACE (City and state or country) <u>Clark County, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Joseph Graham</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Gallon</u>		14. NAME OF HUSBAND OR WIFE <u>Frank Bainter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Sara Mae Gittings, Keokuk, Ia</u>		Address _____	
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>Acute Coronary Thrombosis</u>			<u>10 minutes</u>
DUE TO (b) <u>arteriosclerotic Heart Disease</u>			
DUE TO (c) <u>General Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension</u>			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 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 _____ e.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>July 20, 1961</u> to <u>Aug 5, 1961</u> and last saw her alive on <u>Aug - 5, 1961</u>			
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Cecil L. Watson</u> (Degree & title)		22b. ADDRESS <u>Kahoka, Mo.</u>	22c. DATE SIGNED <u>9-29-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 8, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Day Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Clark County Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>D.L. Shaffer Kahoka, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-28-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

801-7100 WA

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 *D. T. Shaffer*

Licensed Embalmer No. 5063
P. O. Address Kokako, Ia

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.