

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044415

AMENDED

Registration District No. 141 Primary Registration District No. 5550 Registrar's No. 8 STATE FILE NUMBER

FILED JAN 15 1962

1. PLACE OF DEATH
 a. COUNTY Howell
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hocomo Length of stay in 1b 68 yrs.
 c. CITY OR TOWN Hocomo Inside Limits Yes No
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION R. F. D. Inside Limits Yes No
 d. STREET ADDRESS R. F. D. (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) Dola May Kenslow First Middle Last 4. DATE OF DEATH 12-17-1961 Month Day Year

5. SEX F 6. COLOR OR RACE wht. 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 9-11-1893 9. AGE (last birthday) 68 yrs. 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) housewife 10b. KIND OF BUSINESS OR INDUSTRY Howell Co., Mo. 11. BIRTHPLACE (City and state or country) U. S. A. 12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME Thomas Marshall 13b. MOTHER'S MAIDEN NAME Parlie Carroll 14. NAME OF HUSBAND OR WIFE Ed Kenslow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Ed Kenslow, Hocomo, 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) Cerebral Vascular Accident INTERVAL BETWEEN ONSET AND DEATH - 0 -
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension 1 Day
 DUE TO (c) A S C V D ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus 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 Month, Day, Year a.m. p.m.

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 4-21-41 to 9-5-61 and last saw her alive on 9-5-61 Death occurred at 4:40 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dwight E. Wilson, M.D. 22b. ADDRESS West Plains, Mo. 22c. DATE SIGNED 12-22-61

23a. BURIAL, CREMATION, REMOVAL (Specify) B 23b. DATE 12-19-1961 23c. NAME OF CEMETERY OR CREMATORY South Fork Cem. 23d. LOCATION (City, town, or county) (State) South Fork, Mo.

24. FUNERAL DIRECTOR ADDRESS Robertsons, West Plains, Mo. 25. DATE RECD. BY LOCAL REG. 1-11-62 26. REGISTRAR'S SIGNATURE Beatrice Cook

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *A. A. Roberts*

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.