

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-009886

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 164

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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MEDICAL CERTIFICATION

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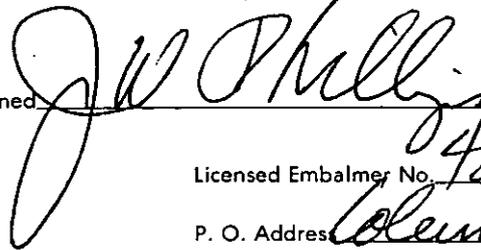
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|---|--|--|--|---|---|
| <p>FILED MAR 26 1962</p> | | <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>BOONE</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u> Length of stay in lb <u>51 days</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UNIV. OF MO. MED. CENTER</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> | | <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY <u>CARROLL</u></p> <p>c. CITY OR TOWN <u>HALE</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS <u>R.R. 1</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> | |
| <p>3. NAME OF DECEASED (Type or print) First Middle Last <u>MILLARD ERIE KINNISON</u></p> | | | <p>4. DATE OF DEATH Month Day Year <u>3 16 62</u></p> | | |
| <p>5. SEX <u>MALE</u></p> | <p>6. COLOR OR RACE <u>WHITE</u></p> | <p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p> | <p>8. DATE OF BIRTH <u>3-12-81</u></p> | <p>9. AGE (last birthday) <u>81</u></p> | <p>IF UNDER 1 YEAR Months Days Hours Min.</p> |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABORER</u></p> | | <p>10b. KIND OF BUSINESS OR INDUSTRY</p> | | <p>11. BIRTHPLACE (City and state or country) <u>BETHANY, MISSOURI</u></p> | |
| <p>12. CITIZEN OF WHAT COUNTRY <u>USA.</u></p> | | <p>13a. FATHER'S NAME <u>THEODORE KINNISON</u></p> | | <p>13b. MOTHER'S MAIDEN NAME <u>MARY</u></p> | |
| <p>14. NAME OF HUSBAND OR WIFE</p> | | <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u></p> | | <p>16. SOCIAL SECURITY NO. <u>—</u></p> | |
| <p>17. INFORMANT MED. RECORDS Address <u>UNIV. OF MO. MED. CENTER Columbia, Mo.</u></p> | | <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Staphylococcal parotitis</u> <u>4 weeks</u></p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma pancreas</u></p> <p>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</p> | | | |
| <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> | <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p> | | | |
| <p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p> | | <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> | | | |
| <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>20f. CITY, TOWN, OR LOCATION</p> | | <p>COUNTY STATE</p> | |
| <p>21. I attended the deceased from <u>2-6-62</u> to <u>3-16-62</u> and last saw her/him alive on <u>3-16-62</u></p> <p>Death occurred at <u>2:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p> | | | | | |
| <p>22a. SIGNATURE (Degree or title) <u>Frank J. Matillle M.D.</u></p> | | | <p>22b. ADDRESS <u>Univ. Med. Center</u></p> | | <p>22c. DATE SIGNED <u>3-16-62</u></p> |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u></p> | | <p>23b. DATE <u>3-17-1962</u></p> | <p>23c. NAME OF CEMETERY OR CREMATORY <u>AVALON CEMETERY</u></p> | | <p>23d. LOCATION (City, town, or county) (State) <u>LIVINGSTON COUNTY, MO</u></p> |
| <p>FUNERAL DIRECTOR ADDRESS <u>PARKERS FUNERAL SERVICE MO. Columbia</u></p> | | <p>25. DATE RECD. BY LOCAL REG. <u>MAR 17, 1962</u></p> | | <p>26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u></p> | |

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



Licensed Embalmer No. 4897

P. O. Address Columbus, 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.