

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **33033**

FILED NOV 1 1955

BIRTH NO. _____		REG. DIST. NO. <u>142</u>		PRIMARY REG. DIST. NO. <u>3386</u>		Registrar's No. <u>503</u>	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howell</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Goldsberry Twnshio</u>		c. LENGTH OF STAY (In this place) <u>3 days</u>		c. CITY OR TOWN <u>Mountain View</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorila Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>04600</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <u>Susan</u>		b. (Middle) <u>Mildred</u>		c. (Last) <u>Gritton</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 22, 1955</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>April 16, 1875</u>	
9. AGE (In years last birthday) <u>80</u>		10. UNDER 1 YEAR <u>5</u> MONTHS <u>6</u> DAYS <u>0</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Anderson County Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		13. FATHER'S NAME <u>Alvin G. Herndon</u>			
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Mildred Catlett</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Ada Becker.</u> ADDRESS <u>Mountain View, Mo.</u>			
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				<b>MEDICAL CERTIFICATION</b>			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Intestinal Obstruction 4 da.</u> DUE TO (c) <u>Sclerosis</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Harold Miller M.D.</u>				23b. ADDRESS <u>Willow Springs, Mo.</u>		23c. DATE SIGNED <u>9-27-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 25, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Arroll Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Arroll, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>10/25</u>		REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Duncan Funeral Home.</u> ADDRESS <u>Mtn. View, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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. 43

P. O. Address Int. Du

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.