

FILED JAN 21 1947

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

554

State File No. \_\_\_\_\_

Registration District No. 64

Primary Registration District No. 4109

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Chariton  
(b) City or town Kennett  
(c) Name of hospital or institution: St. Mary at Kennett  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community all her life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Chariton  
(c) City or town Kennett  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A.? ✓ years

3. (a) PRINT FULL NAME MARY-E. VINCENT.

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife R.D. Vincent 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept. 2nd 1860

8. AGE: Years 86 Months 4 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Scranton Pa.

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name John H. Shivers  
13. Birthplace Bellford England  
14. Maiden name Hannah Cooper  
15. Birthplace Savannah Mo.

16. (a) Informant Mary E. Vincent  
(b) Address Kennett Mo.

17. (a) Burial (b) Date thereof Jan 8-1947  
(c) Place: burial or cremation Kennett Mo.

18. (a) Signature of funeral director W. J. Garretts  
(b) Address Kennett

19. (a) 1-11-47 (b) G. W. Hankins  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 6th  
year 1947 hour 2 minute 25P. M.

21. I hereby certify that I attended the deceased from Oct 14 1942 to January 6 1947  
that I last saw her alive on January 6 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Ch. Myocarditis  
Due to Ch. endocarditis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 5 months of death) \_\_\_\_\_

Major findings: Of operations 9/7/47  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury ✓

23. Signature Carl C. Keen (M. D. certificate)  
Address Kennett Mo Date signed 1/14/47

Duration  
Sept  
Keen  
Sept  
Keen

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

21  
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RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

1-18-47

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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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*H. D. Garnett*

Licensed Embalmer No. \_\_\_\_\_

3046

P. O. Address \_\_\_\_\_

*Keytesville 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 this body is not embalmed, above space should be left blank.