S. No. 300
v. 10.48

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

FILED FEB 9 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1605

Registrar's No. 39

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Research Hospt

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Missouri
b. COUNTY: Vernon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nevada Mo
d. STREET ADDRESS (If rural, give location): 108 7 X

3. NAME OF DECEASED (Type or Print)
a. (First): Mattie
b. (Middle):
c. (Last): Rinehart

4. DATE OF DEATH (Month) (Day) (Year): 1 – 4 – 53

5. SEX: F 1
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: July 8 1867
9. AGE (In years last birthday): 85 — If under 1 year: Months / Days — If under 1 hr.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Indiana
12. CITIZEN OF WHAT COUNTRY?: U. S.

13a. FATHER'S NAME: James Quinn
13b. MOTHER'S MAIDEN NAME: Winfee
14. NAME OF HUSBAND OR WIFE: Wm H Rinehart Dec

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S SIGNATURE OR NAME: Mrs Buston Nicholson
ADDRESS: 4211 Bellefontaine

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

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19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-2-, 1953, *to* 1-4-, 1953, *that I last saw the deceased alive on* 1-2-, 1953, *and that death occurred at* 8 30 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. F. Steffen M.D.
23b. ADDRESS: 1103 Grand Ave Kan. City Mo
23c. DATE SIGNED: 1-5-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 1/4/53
24c. NAME OF CEMETERY OR CREMATORY: —
24d. LOCATION (City, town, or county) (State): Nevada Mo

DATE REC'D BY LOCAL REG.: 1-5-53
REGISTRAR'S SIGNATURE: Geraldine Smith
25. FUNERAL DIRECTOR'S SIGNATURE: Stine-McClure
ADDRESS: R C Mo

(Licensed Embalmer's Statement on Reverse Side)

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 _____
Student Embalmer

Signed George L. Trammell

Licensed Embalmer No. 4425

P. O. Address Kansas City

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, fact should be so stated above.