

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH.

10560

State File No. _____

FILED APR 15 1953

BIRTH NO. _____ REG. DIST. NO. 198 PRIMARY REG. DIST. NO. 574I Registrar's No. 123

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Russell township</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Russell township</u> <u>0610</u>	
c. LENGTH OF STAY (in this place) <u>30 yr.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1 mile N.W. of New Cambria</u>		d. STREET ADDRESS (If rural, give location) <u>1 mile N.W. of New Cambria</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Morton</u> b. (Middle) <u>Woodford</u> c. (Last) <u>Renoe</u>			4. DATE OF DEATH <u>March 16, 1953</u> (Month) (Day) (Year)		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 18, 1881</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Appleton, Henry co., Missouri</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

13a. FATHER'S NAME <u>William P. Renoe</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Holladay</u>		14. NAME OF HUSBAND OR WIFE <u>Edith R. Jones Renoe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT'S SIGNATURE OR NAME, ADDRESS <u>Mrs. Mary Levell, New Cambria, Mo.</u>	

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		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of liver & stomach</u>		
	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.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>1561</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____		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 March 16, 1953, to Mar-16, 1953, that I last saw the deceased alive on Mar-16, 1953, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. West</u> (Degree or title)		23b. ADDRESS <u>New Cambria, Mo.</u>		23c. DATE SIGNED <u>Mar 17-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-18-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Cambria cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>New Cambria, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>3-30-53</u>		REGISTRAR'S SIGNATURE <u>Josephine King</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Hilliard</u> ADDRESS <u>New Cambria Mo</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 4.6.53
MACON COUNTY HEALTH DEPARTMENT
County File No. 45373
Date Filed 4.8.53

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 *H. O. Gilliland*

Licensed Embalmer No. 4019

P. O. Address *Hutchinsville 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, fact should be so stated above.