

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22566**
Registrar's No. **177**

FILED JUL 7 - 1953

BIRTH NO. _____ REG. DIST. NO. **294** PRIMARY REG. DIST. NO. **3056**

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

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Moberly		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Moberly	
d. FULL NAME OF HOSPITAL OR INSTITUTION 714 Burkholder		d. STREET ADDRESS (If rural, give location) 714 Burkholder	

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) Mary c. (Last) Booth			4. DATE OF DEATH (Month) (Day) (Year) June 28 1953		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, DIVORCED (Specify)	
8. DATE OF BIRTH Oct. 18 1876		9. AGE (In years last birthday) 76		10. UNDER 1 YEAR (Days) (Hours) (Min.) 8 10	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home			11b. KIND OF BUSINESS OR INDUSTRY		
12. CITIZENSHIP OF WHAT COUNTRY? Illinois			13. BIRTHPLACE (City and State or Foreign Country)		

13a. FATHER'S NAME No data		13b. MOTHER'S MAIDEN NAME No data		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Bonnie Patrick Moberly	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Angina pectoris INTERVAL BETWEEN ONSET AND DEATH 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 4202			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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 checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **June 9, 1953**, to **June 18, 1953**, that I last saw the deceased alive on **June 18, 1953**, and that death occurred at **7:15 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Gladys Wright meals		23b. ADDRESS Whitaker Hospital		23c. DATE SIGNED 6-28-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 6-30-53		24c. NAME OF CEMETERY OR CREMATORY Oakland		24d. LOCATION (City, town, or county) (State) Moberly Mo	
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DATE REC'D BY LOCAL REG. 6-30-53		REGISTRAR'S SIGNATURE Leah Shewell Gove		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mahon and Son - Moberly, Mo	
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JUL 2 1950

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 Frank W De Witt

Licensed Embalmer No. 3021

P. O. Address Proberly, 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.