No. 300
10.48

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16564

BIRTH NO. _____ REG. DIST. NO. 183 PRIMARY REG. DIST. NO. 4294 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY Linn
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Browning
c. LENGTH OF STAY (in this place) 6 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Sullivan
c. CITY OR TOWN Humphreys
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location) 1050

3. NAME OF DECEASED (Type or Print)
a. (First) MALISSIA
b. (Middle) ANN
c. (Last) WARRINGTON

4. DATE OF DEATH (Month) May (Day) 11 (Year) 1954

5. SEX Fe
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH 5-14-1863
9. AGE (In years last birthday) 90 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) W. Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Wm T Louther
13b. MOTHER'S MAIDEN NAME
14. NAME OF HUSBAND OR WIFE James Warrington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Mrs Frank Scott ADDRESS Browning Mo

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) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility 331 X

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* July, 1953, *to* May 11, 1954, *that I last saw the deceased alive on* May 10, 1954, *and that death occurred at* 8:35 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Howard Carter M.D.
23b. ADDRESS Browning, Mo
23c. DATE SIGNED May 11/1954

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE 5-14-54
24c. NAME OF CEMETERY OR CREMATORY Humphreys Cem
24d. LOCATION (City, town, or county) (State) Humphreys Mo

DATE REC'D BY LOCAL REG. 5-14 1954
REGISTRAR'S SIGNATURE Elva Crookshanks 166
25. FUNERAL DIRECTOR'S SIGNATURE P K Payne Son ADDRESS Galt Mo

(Licensed Embalmer's Statement on Reverse Side)

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

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was eml

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed....D K Payne Jr.....

Licensed Embalmer No. 34.

P. O. Address ....Galt....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.