

FILED JUN 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19758

BIRTH NO. _____ REG. DIST. NO. 301 PRIMARY REG. DIST. NO. 6040 Registrar's No. 342

1. PLACE OF DEATH a. COUNTY RIPLEY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY RIPLEY	
b. CITY (If outside corporate limits, write RURAL and give town) RURAL - POYNOR		c. CITY OR TOWN POYNOR d. Is Residence within limits of a city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. LENGTH OF STAY (in this place) 8 YEARS		e. STREET ADDRESS (If rural, give location) 12 MILES So. OF DONIPHAN	
d. FULL NAME OF HOSPITAL OR INSTITUTION 12 MI. So. OF DONIPHAN			

3. NAME OF DECEASED (Type or Print)	a. (First) AMANDA	b. (Middle) ELLA	c. (Last) KINNAMAN	4. DATE OF DEATH (Month) (Day) (Year) JUNE 10-1955
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH AUG. 6-1878	9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months 10 Days 4 Hours Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	BIRTHPLACE (City and State or Foreign Country) Norwood - Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ERIGH DUGANEY	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE DECEASED
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME HARRY KINNAMAN - DONIPHAN	ADDRESS DONIPHAN
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myo. cardiac degeneration		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertension		
	DUE TO (c) 44:3X		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ulcer of stomach			

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) ---
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? ---
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22. I hereby certify that I attended the deceased from June 7, 1955, to June 10, 1955; that I last saw the deceased alive on June 7, 1955, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE Steuwhite (Degree or title) MD	23b. ADDRESS Rayloy rd	23c. DATE SIGNED 6/11/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/12/55	24c. NAME OF CEMETERY OR CREMATORY POYNOR CEM.	24d. LOCATION (City, town, or county) (State) POYNOR - Mo.
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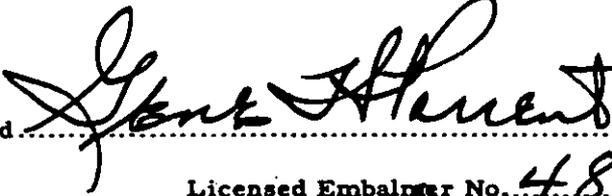
DATE REC'D BY LOCAL REG. 6-14-1955	REGISTRAR'S SIGNATURE Ed Johnson 277	25. FUNERAL DIRECTOR'S SIGNATURE EDWARDS FUNERAL HOME	ADDRESS DONIPHAN - Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 48

P. O. Address 

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.