

U.S. Health, & Welfare S. Public Health Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39540

FILED DEC 9 - 1957

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 5209 Registrar's No. 107

S. 300  
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Leslie township</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Bogard</u> 0179 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>Leslie twp</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>J.</u> Last <u>MINNIS</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 27, 1858</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	9. AGE (In years last birthday) <u>99</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u> Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Carrollton, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James H. Minnis</u>		14. MOTHER'S MAIDEN NAME <u>Melinda Toberman</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>-</u>	17. INFORMANT Address <u>Maud Minnis, Bogard, Mo</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>tumor of tongue, severity 2 yrs</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) _____			INTERVAL BETWEEN ONSET AND DEATH _____
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE _____	
21. I attended the deceased from <u>12-3-57</u> to <u>12-5-57</u> and last saw her/him alive on <u>12-5-57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Herbert Caldwell</u> (Degree or title)		22b. ADDRESS <u>Carrollton</u>	22c. DATE SIGNED <u>12-5-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-8-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>	23d. LOCATION (City, town, or county) (State) <u>Bogard Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>R. E. Dickerson Bogard, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-6-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert Caldwell</u>

(Licensed Embalmer's Statement on Reverse Side)

450

VS DEC 28 1959

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 *R.M. Marshall*

Licensed Embalmer No. *446*

P. O. Address *Quailton*

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.