

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022116

STATE FILE NUMBER

NEW JUN 17 1959 Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 159

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Chillicothe</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Tina</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Susans Nursing Home 2 years</b>		Length of stay in 1b	d. STREET ADDRESS <b>RFD</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>AMANDA</b> Middle <b>ELLEN</b> Last <b>ROCKHOLD</b>			4. DATE OF DEATH Month <b>June</b> Day <b>6th</b> Year <b>1959</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 7 1861</b>		9. AGE (In years last birthday) <b>98</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Carroll County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Mathew Breckenridge</b>		13b. MOTHER'S MAIDEN NAME <b>Mary</b>		14. NAME OF HUSBAND OR WIFE <b>J.G. Rockhold</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs Frank Colliver, Tina, Mo. RFD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-VASCULAR-RENAL FAILURE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Squamous Cell CA. Rt Maxillary &amp; Frontal sinuses</b>					<b>3 yrs.</b>
DUE TO (c) <b>Senility</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <b>1608</b>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>MAY 10 - 1942</b> , to <b>6-6-59</b> , and last saw her <sup>him</sup> alive on <b>6-6-59</b> . Death occurred at <b>1:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>R.W. Mathewy D.O.</b>			22b. ADDRESS <b>Chillicothe, Missouri</b>		22c. DATE SIGNED <b>6-11-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 9, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Coloma Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Tina, Missouri.</b>
24. FUNERAL DIRECTOR <b>Clifford W. Austin, Tina, Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>6/11/59</b>	26. REGISTRAR'S SIGNATURE <b>Francis B. Nell</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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. 3233  
P. O. Address Tina, Missouri.

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.