

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-039727**  
STATE FILE NUMBER

Registration District No. 142 Primary Registration District No. 4231 Registrar's No. \_\_\_\_\_

**FILED NOV 8 1963**

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mountain View</u>		Length of stay in 1b <u>7 Days</u>	c. CITY OR TOWN <u>Willow Springs</u> 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>St. Francis Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. #3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Mitchell J. QUINN</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/87</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Monmouth, Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Perry Quinn</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Thompson</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Nora Quinn</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. [Redacted]	17. INFORMANT Address <u>Mrs. Nora Quinn, Rt #3, Willow Spgs, Mo</u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>acute coronary accident</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>myocarditis chronic</u>	
	DUE TO (c) <u>arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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 10-26-63 to 11/3/63 and last saw her alive on 11-2-63  
Death occurred at 1:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Harold W. Miller, M.D.</u>	22b. ADDRESS <u>Willow Springs, Mo.</u>	22c. DATE SIGNED <u>11/4/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/5/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Willow Springs, Mo.</u>
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24. FUNERAL DIRECTOR <u>Burns - Willow Springs, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-6-1963</u>	26. REGISTRAR'S SIGNATURE <u>Charles D. Carter</u>
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DO NOT WRITE ON THIS STUB  
 AMENDED  
 DATE AMENDED  
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 2 0460  
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 8 2  
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 ITEM NO.  
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

NOV 18 1963

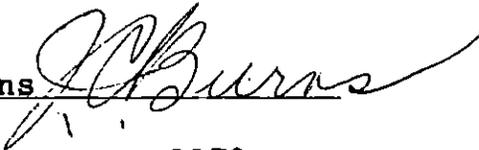
**STATEMENT BY LICENSED EMBALMER**

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 J. C. Burns 

Licensed Embalmer No. 3379

P. O. Address Willow Springs, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.