No. 300
10-48

FILED JAN 25 1956

Rollins

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 3515

BIRTH NO. ____ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. 6137 Registrar's No. 346

1010

**1. PLACE OF DEATH**
a. COUNTY: Shannon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Winona Twp
c. LENGTH OF STAY (in this place): 63 yr.
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: Shannon
c. CITY OR TOWN: Winona
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒
e. STREET ADDRESS (If rural, give location):

1010

**3. NAME OF DECEASED** (Type or Print): a. (First) Manda b. (Middle) Missouri c. (Last) Hill

**4. DATE OF DEATH** (Month) (Day) (Year): Jan. 20-1956

**5. SEX:** F

**6. COLOR OR RACE:** W

**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Widowed

**8. DATE OF BIRTH:** March 31-1875

**9. AGE** (In years last birthday): 80 — If under 1 year: Months 9, Days 20 — 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): Lawrence Co. Ohio

**12. CITIZEN OF WHAT COUNTRY?** U.S.

**13a. FATHER'S NAME:** Robert Neal

**13b. MOTHER'S MAIDEN NAME:** Caroline Beleat

**14. NAME OF HUSBAND OR WIFE:**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service): No

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT'S SIGNATURE OR NAME / ADDRESS:** Mrs Chet Neal Winona, Mo.

## MEDICAL CERTIFICATION

**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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cebral Hemmorhage

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

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

4222

INTERVAL BETWEEN ONSET AND DEATH:

**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* Jan *, 19*50*, to* Jan 6 *, 19*56 *that I last saw the deceased alive on* Jan 6 *, 19*56 *and that death occurred at* 3:10 P *m., from the causes and on the date stated above.*

**23a. SIGNATURE:** J A Rollins (Degree or title) M.D.
**23b. ADDRESS:** Winona Mo
**23c. DATE SIGNED:** 1/23-56

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE:** Jan. 22-56
**24c. NAME OF CEMETERY OR CREMATORY:** Mt. Zion
**24d. LOCATION** (City, town, or county) (State): Winona, Mo.

**DATE REC'D BY LOCAL REG.:** 1-23-56
**REGISTRAR'S SIGNATURE:** Mabel Rogers 447
**25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS:** Duncan's Mt. View, 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 embal

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

working under my personal supervision..

Student .............................................. Signed Joe L. Duncan ..........
Signature of Student Embalmer

Licensed Embalmer No. #32

P. O. Address Mt. View,

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