

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10836

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ FILED MAR 30 1954 REG. DIST. NO. 319 PRIMARY REG. DIST. NO. 6081 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY Ste. Genevieve		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Ste. Genevieve	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Union Twp.		c. CITY OR TOWN Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION RFD#2, Farmington		e. STREET ADDRESS (If rural, give location) RFD#2, Farmington	

3. NAME OF DECEASED (Type or Print) a. (First) Nellie	b. (Middle)	c. (Last) Quinton	4. DATE OF DEATH (Month) (Day) (Year) March 23 1954
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec 16 - 1884	9. AGE (In years last birthday) 69	10. MONTHS 3	11. DAYS 7	12. IF UNDER 1 YEAR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Madelon County, Mo.	12. CITIZEN OF WHAT COUNTRY? Ste. Genevieve Co., Mo.
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13a. FATHER'S NAME James Killiam	13b. MOTHER'S MAIDEN NAME Barbara Pope	14. NAME OF HUSBAND OR WIFE Chas. Quinton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 490-24-5133	17. INFORMANT'S SIGNATURE OR NAME Mrs. Arnold Bejington	ADDRESS RFD#2
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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.	MEDICAL CERTIFICATION Farmington Mo.		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Disease		3 months
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		3 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 Feb 8, 1954, to March 23 1954, that I last saw the deceased alive on March 20, 1954, and that death occurred at 5:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE Dr. Geo. H. W. [Signature]	(Degree or title)	23b. ADDRESS Farmington Mo.	23c. DATE SIGNED 3-24-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 25, 1954	24c. NAME OF CEMETERY OR CREMATORY Christian Cemetery	24d. LOCATION (City, town, or county) (State) Fredericktown, Mo.
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DATE REC'D BY LOCAL REG. Mar. 26, 1954	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Cozean Funeral Home, Farmington, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
10-48  
900

APR 2

STATEMENT BY LICENSED EMBALMER

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

Student.....  
Signature of Student Embalmer

Signed.....  
*C. A. Cozear*

Licensed Embalmer No. 4.....

P. O. Address *Harmis*.....

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