

JAN 15 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

44784  
Do not use this space.

1. PLACE OF DEATH  
 (a) County BUCHANAN Registration District No. 85  
 (b) Township \_\_\_\_\_ Primary Registration District No. 10  
 (c) City ST. JOSEPH (d) Street No. St. Joseph Hospital Registered No. 1389  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
 (e) Length of residence in city or town where death occurred yrs. mos. 7 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME OSCAR ELI FIKE  
 (a) Residence, No. MOUND CITY - MO St.  Mound City Mo.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWER

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) NOV. 16 - 1871

7. AGE YEARS 66 MONTHS 1 DAYS 3 If LESS than 1 day, .....hrs. or .....min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. LABORER

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) UNKNOWN (STATE OR COUNTRY) UNKNOWN 31

13. NAME Wm. FIKE 31

14. BIRTHPLACE (CITY OR TOWN) UNKNOWN (STATE OR COUNTRY) UNKNOWN 31

15. MAIDEN NAME SARAH SHIELDS

16. BIRTHPLACE (CITY OR TOWN) UNKNOWN (STATE OR COUNTRY) UNKNOWN

17. INFORMANT Miss Warren (ADDRESS) Mound City Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE MOUND CITY DATE DEC-21-1937

19. FUNERAL DIRECTOR J. FRED TERHUNE (ADDRESS) SAVANNAH MO

20. FILED Dec 20 1937 W. Neelbush Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 19 1937

22. I HEREBY CERTIFY, That I attended deceased from Dec 12 1937 to Dec 19 1937

I last saw him alive on Dec 18 1937 Death is said to have occurred on the date stated above, at 5:30 P.M.

The principal cause of death and related causes of importance were as follows:  
Labor Pneumonia Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Clogged Chest from Auto Accident

Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide Accident Date of injury Dec 9 1937  
 Where did injury occur Near Mound City, Mo.  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. Highway

Manner of injury Automobile Accident  
 Nature of injury Clogged Chest - none Pneumonia

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_

(Signed) W. E. Neelbush M. D.  
 (Address) 607 Francis St. Mound Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

210m

STATEMENT BY LICENSED EMBALMER

I, J. Fred Terhune, Licensed Embalmer No. 1279

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No..... or by....., Registered Apprentice No.....  
working under my personal supervision.

Signed J. Fred Terhune  
Licensed Embalmer No. 1279

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

44784  
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85  
(b) Township \_\_\_\_\_ Primary Registration District No. 1001 Registered No. 1389  
(c) City St. Joseph (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Oscar Eli Fike

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
66 1 3

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 19 1937

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

I last saw h \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

Supplemental  
Subacute Pneumonia  
Crushed chest from auto accident  
Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. Death was due to external cause (Homicide), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) A. E. Burghen, M. D.  
(Address) 629 Francis St. St. Joseph Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTAL  
Dec 19 1937  
Fike  
Fike

