

FILED MAY 9 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **12082**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **399**

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b> c. LENGTH OF STAY (in this place) <b>3 wks</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b> <b>2</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>425 - E - Tampa</b>	
3. NAME OF DECEASED a. (First) <b>ETTA</b> b. (Middle) _____ c. (Last) <b>PIKE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 3 49</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec-5-1887</b>
9. AGE (In years last birthday) <b>61</b> Months <b>5</b> Days _____		10. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) <b>Housewife</b>	
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Cave Springs Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>James Stroud</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
13c. FATHER'S NAME <b>James Stroud</b>		14. NAME OF HUSBAND OR WIFE <b>Earl Pike</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Earl Pike</b>		17. ADDRESS <b>425 - E - Tampa</b>	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Myocardial Insufficiency</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		431X	
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) (Min) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>July 24, 1948</b> , to <b>May 3, 1949</b> , that I last saw the deceased alive on <b>May 3, 1949</b> , and that death occurred at <b>11:00 A. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Lynmar W. Brown</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>311 1/2 Boonville, Springfield Mo.</b>	
23c. DATE SIGNED <b>May 4, 1949</b>		23d. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5-8-49</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Cave Springs Mo.</b>		24d. LOCATION (City, town, or county) (State) <b>Cave Springs Mo.</b>	
DATE REC'D BY LOCAL REG. <b>5-6-49</b>		REGISTRAR'S SIGNATURE <b>M. E. Handley</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>H. V. Smith</b>		ADDRESS <b>602 - N - Jefferson</b>	

(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 embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Hubert V. Smith*

Licensed Embalmer No. \_\_\_\_\_

*4286*

P. O. Address \_\_\_\_\_

*Springfield*

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