

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **38281**

FILED DEC 1 1949

BIRTH NO. _____		REG. DIST. NO. <b>278</b>		PRIMARY REG. DIST. NO. <b>3054</b>		Registrar's No. <b>96</b>	
<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).			
a. COUNTY <b>Pike Co. Hospital</b>		a. STATE <b>Mo.</b>		b. COUNTY <b>Pike Co.</b>			
b. CITY OR TOWN <b>Roussin Mo.</b>		c. LENGTH OF STAY (in this place) <b>29</b>		c. CITY OR TOWN <b>Colia Mo.</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Pike County Hospital</b>				d. STREET ADDRESS (If rural, give location) _____			
<b>3. NAME OF DECEASED</b>			<b>4. DATE OF DEATH</b>				
a. (First) <b>Bessie</b>		b. (Middle) <b>Hertrude</b>		c. (Last) <b>Irvin</b>		Date: (Month) (Day) (Year) <b>Nov. 18 1949</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>W.</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>W</b>		<b>8. DATE OF BIRTH</b> <b>April 10, 1878</b>	
<b>9. AGE</b> (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House wife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Colia Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13a. FATHER'S NAME</b> <b>John Pellard</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Anne Christian</b>			<b>14. NAME OF HUSBAND OR WIFE</b> _____	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>76</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Wm W. Irvin</b> <b>Louisiana Mo</b>			
<b>18. CAUSE OF DEATH</b>		<b>MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
Enter only one cause per line for (a), (b), and (c)		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Embolicism - cerebral</b>					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<b>ANTECEDENT CAUSES</b>					
		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) <b>Fracture femur + humerus</b>					
		DUE TO (c) <b>Car accident -</b>				<b>4-28-11</b>	
		<b>II. OTHER SIGNIFICANT CONDITIONS</b>				<b>26</b>	
		Conditions contributing to the death but not related to the disease or condition causing death.					
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>None</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT</b> (Specify) <b>Car accident</b>		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office, bldg., etc.) <b>Colia Mo</b>		<b>21c. CITY, TOWN, OR TOWNSHIP</b> <b>Colia Mo</b>		<b>(COUNTY)</b> <b>Pike Mo</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (m.) _____		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <b>Car Collision - Coll. w. 11-17-1949</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>10-20, 1949, to 11-18, 1949,</b> <b>that I last saw the deceased alive on</b> <b>11-17, 1949,</b> <b>and that death occurred at</b> <b>7:10 a.m.,</b> <b>from the causes and on the date stated above.</b>							
<b>23a. SIGNATURE</b> <b>Bernice Collier</b> (Degree or title) _____				<b>23b. ADDRESS</b> <b>Louisiana Mo.</b>		<b>23c. DATE SIGNED</b> <b>11-18-49</b>	
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24b. DATE</b> <b>Nov 20-1949</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>St John Cemetery</b>		<b>24d. LOCATION</b> (City, town, or county) <b>Colia</b> (State) <b>Mo</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>Nov 19, 1949</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Bernice Collier</b> <b>374</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Mc Cue Funeral Service</b>		<b>ADDRESS</b> _____	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

87  
2  
1

DEC 20 1949

RECEIVED NOV 28 1949  
District Health Officer No. 10  
District File Number 11-49-96  
Data Filed NOV 28 1949

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.

Signed Norman E. Gooch

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2342

P. O. Address Esolia 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 this body is not embalmed, fact should be so stated above.