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

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

FILED JUN 25 1951  
 JUN 25 1951

State File No. **20885**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **254** PRIMARY REG. DIST. NO. **4386** Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Oregon</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Haskell</b>	
b. CITY (if outside corporate limits write RURAL and give name of town) <b>Thayer R 3rd</b>		c. CITY OR TOWN (if outside corporate limits write RURAL and give township) <b>West Thayer 0461</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If rural, give location) <b>1</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) <b>Gordon David Livingston</b> a. (First) <b>Gordon</b> (Middle) <b>David</b> (Last) <b>Livingston</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>5-31-51</b>		
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> <b>M</b>	<b>8. DATE OF BIRTH</b> <b>5-20-1912</b>	<b>9. AGE</b> (In years last birthday) <b>39</b>	<b>IF UNDER 1 YEAR</b> Months <b>11</b> Days _____ Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (State or foreign country) <b>West Thayer Mo</b>	

<b>13a. FATHER'S NAME</b> <b>Chas. Livingston</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Leila Little</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Aileen Livingston</b>	
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____	<b>16. SOCIAL SECURITY NO.</b> <b>500-05-7902</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Aileen Livingston, Thayer</b>		<b>ADDRESS</b> <b>Thayer, Mo</b>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>11</b> <b>37</b>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)</b> <b>Broken Neck</b>		
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Car overturned on Highway 63</b> <b>5 Miles north of Thayer, Mo.</b> DUE TO (c) _____		
<b>II. OTHER SIGNIFICANT CONDITIONS</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>075</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT</b> (Specify) <b>Accident</b>	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <b>Thayer Mo</b>
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>5-31-51-4:00 a.m.</b>	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> _____

22. I hereby certify that I attended the deceased from 19 4:00 19, that I last saw the deceased alive on 19, and that death occurred at 4:00 m., from the causes and on the date stated above.

<b>23a. SIGNATURE</b> <b>Steph (Doc) Martin Carver</b>	(Degree or title) _____	<b>23b. ADDRESS</b> <b>Thayer Mo.</b>	<b>23c. DATE SIGNED</b> <b>6-10-51</b>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>U-n</b>	<b>24b. DATE</b> <b>5-31-51</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Lawn</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>West Thayer Mo</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>6-18-51</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Ella Cross 416</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robertson, Matthew Mo</b>	<b>ADDRESS</b> <b>Thayer Mo</b>
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JUN 4 1951

JUL 20 1951

JUL 18 1951

JUL 24 1951

JUL 25 1951

RECEIVED

JUN 23 1951

DISTRICT HEALTH OFFICE No. 6

No. No.....

JUN 27 1951

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.....

*A. A. Roberts*

Licensed Embalmer No. *3437*

P. O. Address *West Haven*

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.