

FILED MAY 19 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16106**

BIRTH NO.		REG. DIST. NO. 128	PRIMARY REG. DIST. NO. 2000	Registrar's No. 482
1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lawrence		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Verona, Rural 0550		
c. LENGTH OF STAY (in this place) 8 Days		d. STREET ADDRESS (If rural, give location) Route # 1		
d. FULL NAME OF HOSPITAL OR INSTITUTION OSZARK OSTEOPATHIC HOSPITAL				
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Martin c. (Last) Paskie		4. DATE OF DEATH (Month) (Day) (Year) 5/14/1952		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4-8-1877	9. AGE (in years last birthday) 75 IF UNDER 1 YEAR: Months 1 Days 6 IF UNDER 24 HRS. Hours 6 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Winona, Minn.
12. CITIZEN OF WHAT COUNTRY U. S.				
13a. FATHER'S NAME Valentine Paskie		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mrs. Annie Paskie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Josephine McAllister, Washington D.C.
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) Cardiac Decompensation 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 4343		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) (Minute)		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 5/6/52 , 19___, to 5/14/52 , 19___; that I last saw the deceased alive on 5/14/52 , 19___, and that death occurred at 1:30P m. , from the causes and on the date stated above.				
23a. SIGNATURE <i>James B. Amos</i>		23b. ADDRESS 700 E. Sunshine, Springfield		23c. DATE SIGNED 5/14/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5/14/52		24c. NAME OF CEMETERY OR CREMATORY, Unknown
24d. LOCATION (City, town, or county) (State) Monett, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>J. B. Buchanan Monett</i>		
DATE REC'D BY LOCAL REG. 5-15-52		REGISTRAR'S SIGNATURE <i>James B. Amos</i>		

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

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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 _____

working under my personal supervision.

Student embalmer No.

Signed _____

J. P. Buchanan

Signed.....
Student Embalmer

Licensed Embalmer No. 3179

P. O. Address. Monroeville 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.