

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38738

State File No. ....

FILED DEC 14 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1095

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ozark</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield, Mo</u>		c. CITY OR TOWN <u>Gainesville</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>3 yrs</u>		e. STREET ADDRESS (If rural, give location) <u>0770</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Havener Rest Home</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Noah</u> b. (Middle) _____ c. (Last) <u>Bivins</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12-7-1953</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-11-1862</u>
9. AGE (In years last birthday) <u>91</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>J. W. Bivins</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Amanda Ellen McCullough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>W. M. Morrison Gainesville, Mo</u>	

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Artery Thrombosis</u>		ANTECEDENT CAUSES		DUE TO (b) _____	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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 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) <u>332X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 1952, to Dec 7, 1953, that I last saw the deceased alive on Dec 6, 1953, and that death occurred at 10:05 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James Ford MD</u>		23b. ADDRESS <u>Springfield, Mo</u>		23c. DATE SIGNED <u>12-10-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>12-10-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Smiths Chapel</u>	
24d. LOCATION (City, town, or county) (State) <u>rural Ozark, ct. Mo</u>					

DATE REC'D BY LOCAL REG. <u>12-11-53</u>		REGISTRAR'S SIGNATURE <u>Paula Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Clinkingbeard Gainesville, Mo</u>	
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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.....  
Signature of Student Embalmer

Signed *John B. Carey*.....

Licensed Embalmer No. *4885*

P. O. Address *Cambridge*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.