

FILED JUN 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17788**

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

| | | | | | | | |
|--|---|--|---|---|--|---|---------------------------------|
| BIRTH NO. _____ | | REG. DIST. NO. <u>1</u> | | PRIMARY REG. DIST. NO. <u>3000</u> | | Registrar's No. <u>156</u> | |
| 1. PLACE OF DEATH a. COUNTY Adair | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville | | c. LENGTH OF STAY (In this place) 8 mo. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville | | 0063 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 114 South Wabash | | | | d. STREET ADDRESS (If rural, give location) 114 South Wabash | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) John | | b. (Middle) Wessley | | c. (Last) O'Haver | | 4. DATE OF DEATH (Month) (Day) (Year) June 4, 1954 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH March 12, 1880 | | 9. AGE (In years last birthday) 74 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Mins. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own farm | | 11. BIRTHPLACE (State or foreign country) Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME Solomon O'Haver | | 13b. MOTHER'S MAIDEN NAME Margaret McCormick | | 14. NAME OF HUSBAND OR WIFE Minnie O'Haver | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 431-12-2534 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Minnie O'Haver, Kirksville, Mo. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Anoxia ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) Acute Purpura Pulmonale DUE TO (c) Morbillia infection of lung II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 min. 1 min. 1 mo? | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 1343 | | | | 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) | | 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 <u>May</u> , 19 <u>54</u> , to <u>June 4</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>June 2</u> , 19 <u>54</u> , and that death occurred at <u>2 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Doctor or other) W. G. Gutzwiller M.D. | | | | 23b. ADDRESS Kirksville Mo | | 23c. DATE SIGNED 6-4-54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE June 7, 1954 | 24c. NAME OF CEMETERY OR CREMATORY Green Castle Cemetery | | 24d. LOCATION (City, town, or county) (State) Green Castle, Mo. | | |
| DATE REC'D BY LOCAL REG. 6-7-54 | | REGISTRAR'S SIGNATURE Kate Lambert 1-0 | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alma E. Kent Esq. Green City, Mo. | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

Harold R. Kent

Signed.....
Student Embalmer

Licensed Embalmer No. *4689*

P. O. Address *Green City, 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.