

FILED MAR 2 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5789

BIRTH NO. _____		REG. DIST. NO. 278		PRIMARY REG. DIST. NO. 3054		Registrar's No. 29		
1. PLACE OF DEATH a. COUNTY Pike 0821				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Pike				
b. CITY OR TOWN Louisiana		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN Eolia		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Pike Co Hosp.				e. STREET ADDRESS (If rural, give location) 0820				
3. NAME OF DECEASED (Type or Print) a. (First) Clara b. (Middle) Wallace c. (Last) Achor			4. DATE OF DEATH (Month) (Day) (Year) 2-22-55					
5. SEX Female	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-12-1884		9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work and during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Eolia Mo 0		12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME William Atkins		13b. MOTHER'S MAIDEN NAME Florence Johnson		14. NAME OF HUSBAND OR WIFE Elbert P. Achor				
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elbert P. Achor				
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) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) #221 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Cholecystitis					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 2-11-55		19b. MAJOR FINDINGS OF OPERATION Chronic Cholecystitis				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, highway)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY		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 1-23, 1955, to 2-22, 1955, that I last saw the deceased alive on 2-21, 1955, and that death occurred at 2:55 AM, from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title)				23b. ADDRESS		23c. DATE SIGNED		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/24/55		24c. NAME OF CEMETERY OR CREMATORY Auburn Cemetery		24d. LOCATION (City, town, or county) (State) Lincoln Co Mo		
DATE REC'D BY LOCAL REG. 2/24/55		REGISTRAR'S SIGNATURE Bernice Collier 374		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Geo M Collier Louisiana Mo				

(Licensed Embalmer's Statement on Reverse Side)

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 ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.