

Ollie Bell Haught  
FILED NOV 30 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37755

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>278</u>		PRIMARY REG. DIST. NO. <u>2054</u>		Registrar's No. <u>130</u>	
1. PLACE OF DEATH a. COUNTY <u>PIKE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>LOUISIANA</u>		c. LENGTH OF STAY (in this place) <u>76 yrs</u>		c. CITY OR TOWN <u>LOUISIANA</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>117 1/2 SOUTH THIRD ST.</u>				STREET ADDRESS (If rural, give location) <u>117 1/2 SOUTH THIRD ST.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>OLLIE</u>		b. (Middle) <u>BELL</u>		c. (Last) <u>HAUGHT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 21 1955</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>MARCH 4, 1871</u>	
9. AGE (In years last birthday) <u>84</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>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>PIKE COUNTY, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>C</u>	
13a. FATHER'S NAME <u>JOHN MARSH</u>		13b. MOTHER'S MAIDEN NAME <u>MARY INGE</u>		14. NAME OF HUSBAND OR WIFE <u>PETER TOBIAS HAUGHT (DEC'D)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. JOHN EDWARDS, LOUISIANA, Mo.</u>			
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
		ANTECEDENT CAUSES		DUE TO (b) <u>Chronic Myocarditis</u>		<u>1 yr</u>	
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <u>4222</u>			
		II. OTHER SIGNIFICANT CONDITIONS		<u>Chronic Bronchial Asthma</u>		<u>5 yrs</u>	
		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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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>April 1950</u> , to <u>Nov. 21, 1955</u> , that I last saw the deceased alive on <u>11-20-55</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Robert L. Ludrae M.D.</u>				23b. ADDRESS <u>Louisiana Mo</u>		23c. DATE SIGNED <u>11/21/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Nov. 23, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>LOUISIANA, MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Bernice Collier</u>		374- 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Geo. M. Collier, Louisiana, Mo</u>			

(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. (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.