

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 1 - 1957

9661

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 42

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 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> COUNTY <u>PIKE</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>LOUISIANA 082</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOSP</u> | | Length of stay in 1b <u>LIFE</u> | d. STREET ADDRESS (If outside, give location) <u>205 So. 25th</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>AMBROSE HUSTON WHITE</u> | | | 4. DATE OF DEATH Month Day Year <u>MAR. 23, 1957</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 10, 1882</u> | | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>73</u> Months Days 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>AGRICULTURE</u> | | 11. BIRTHPLACE (City and state or country) <u>PIKE CO., MO.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>SAM H. WHITE</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARY MELVINA ROOKS</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>NETTIE MAY WHITE</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>492-40-3368</u> | |
| 17. INFORMANT <u>NETTIE M. WHITE, Louisiana, Mo.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism, Rt.</u> DUE TO (b) <u>Acute Congestive Heart Failure.</u> DUE TO (c) <u>Cardiac Hypertrophy 4221</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arterio Sclerotic Cardio-vascular Disease?</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 days</u> <u>?</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION | | COUNTY | | STATE | |
| 21. I attended the deceased from <u>3/13/57</u> to <u>3/23/57</u> and last saw him alive on <u>3/23/57</u> . Death occurred at <u>9:20 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>Robert G. Andrae M.D.</u> | | 22b. ADDRESS <u>Louisiana, Mo.</u> | | 22c. DATE SIGNED <u>3/25/57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>3/25/57</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEM., LOUISIANA, MO.</u> | |
| 23d. LOCATION (City, town, or county) (State) <u>Louisiana, Mo.</u> | | 24. FUNERAL DIRECTOR <u>GEO. M. COLLIER - LOUISIANA, MO.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Mar 25, 1957</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Bernice Callier</u> | | | | | |

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 *Geo. M. Collier*

Licensed Embalmer No. *3839*

P. O. Address *Louisiana*

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.