

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

58-043631

STATE FILE NUMBER

FILED DEC 29 1958

Registration District No. 87

Primary Registration District No.

Registrar's No. 12

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bourbon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bourbon</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home</u>		Length of stay in lb <u>75 YEARS</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>SHAYLES</u> Middle <u>HALPAKER</u> Last <u>HALPAKER</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1958</u>		
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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>Feb 26 1879</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Acton, Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Louis Daniel Halpaker</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Carter Foster</u>	14. NAME OF HUSBAND OR WIFE <u>Oma H. Halpaker</u>
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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 <u>Mrs. Oma Halpaker, Bourbon Mo.</u>	Address
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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>Progressive Cerebral Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerotic heart disease</u>	DUE TO (c) <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</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.)
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>

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 <u></u> STATE <u></u>
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21. I attended the deceased from March 1947 to Dec 1958 and last saw him alive on Dec 18, 1958
Death occurred at 4:25 A. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ronald A. Scott</u> (Degree of title) <u>Dr.</u>	22b. ADDRESS <u>Sullivan Mo.</u>	22c. DATE SIGNED <u>12/20/58.</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-21-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bourbon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bourbon Mo.</u>
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24. FUNERAL DIRECTOR <u>R. P. [Signature]</u> ADDRESS <u>Suba Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 21 1958</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

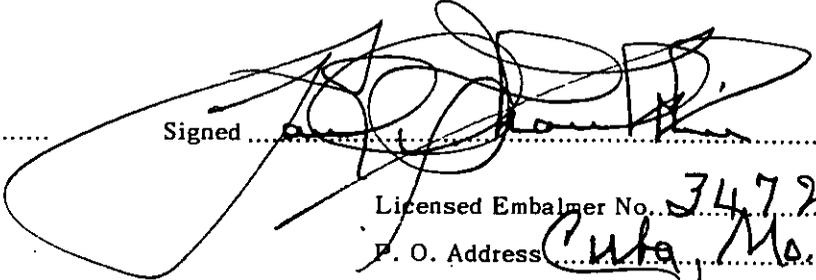
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JAN 8 1959

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. 3472

P. O. Address Cuba, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.