

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

59-009160

STATE FILE NUMBER

FILED MAR 31 1959

Registration District No. 133 Primary Registration District No. \_\_\_\_\_ Registrar's No. 37

10  
5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Harrison</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Harrison</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cainsville</b>		c. CITY OR TOWN <b>Cainsville</b> <sup>0410</sup>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Own home</b>		d. STREET ADDRESS (If outside, give location) <b>40 Yrs.</b>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Ross</b> Middle <b>----</b> Last <b>Childs</b>			4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1959</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 13, 1883</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber &amp; Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm labor</b>	11. BIRTHPLACE (City and state or country) <b>Shawnee, Kansas.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Arthur Childs</b>	13b. MOTHER'S MAIDEN NAME <b>Alice New</b>	14. NAME OF HUSBAND OR WIFE <b>Ola M. Childs.</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>500-07-9861</b>	17. INFORMANT <b>Ola M. Childs, Cainsville, Mo.</b>	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) <b>Metastatic Carcinoma of throat</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b>
DUE TO (b) <b>Primary Carcinoma of gums.</b>		<b>6 months</b>
DUE TO (c) _____		<b>144X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Patient was operated on at Ellis-Fishel Hosp. Columbia, Mo. 3 months ago.</b>		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 _____
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21. I attended the deceased from **February 1, 1959** to **March 18, 1959** and last saw him alive on **March 18, 1959**.  
Death occurred at **9:45 p.m.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>William J. Ellwood</i> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>Cainsville, Mo.</b>	22c. DATE SIGNED <b>3-19-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 21, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zoar Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Cainsville, Missouri.</b>
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24. FURTHER DIRECTOR ADDRESS <i>[Signature]</i> <b>Cainsville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-22-1959</b>	26. REGISTRAR'S SIGNATURE <i>Gella Massey</i>
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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

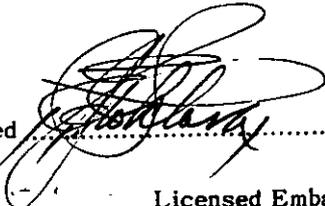
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Eddie J. Stoklasa, Student Embalmer No. ....

working under my personal supervision.

Student .....

Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. 3602 .....

P. O. Address Cainsville, 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.