

Health,  
& Welfare  
Public  
Service

FILED VS OCT 17 1960

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-037755  
STATE FILE NUMBER

Registration District No. 65 Primary Registration District No. \_\_\_\_\_ Registrar's No. 48

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Chariton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Chariton</u>	
b. CITY OR TOWN <u>Marceline</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Marceline</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.F.D. 1</u>		d. STREET ADDRESS (If outside, give location) <u>0214, R.F.D. 1</u>	

3. NAME OF DECEASED (Type or print) First <u>OTIS</u> Middle _____ Last <u>Ball</u>			4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>6-16-1904</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>22</u>
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>General</u>	11. BIRTHPLACE (City and state or country) <u>9</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Willis</u>		13b. MOTHER'S MAIDEN NAME <u>Lavinia Nixon</u>		14. NAME OF HUSBAND OR WIFE <u>Iva</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Mrs. Iva Ball</u> Address <u>Marceline, 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>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u>		
	DUE TO (c) <u>4201</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 _____ 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 12-10-57 to 10-8-60 and last saw him alive 2 yrs ago.  
Death occurred at Approx 6:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James M. Laughlin</u>		22b. ADDRESS <u>121 N KANSAS MARCELINE, MO</u>	22c. DATE SIGNED <u>10-8-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>10-10-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rothwell</u>	23d. LOCATION (City, town, or county) (State) <u>Rothwell, MO.</u>
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24. FUNERAL DIRECTOR <u>James M. Laughlin Marceline, MO</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 12-1960</u>	26. REGISTRAR'S SIGNATURE <u>Loisie Smith</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related. No symptoms will be listed.

*Sm*

OCT 18 1960

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 *Gerald I Wade*

Licensed Embalmer No. *4172*

P. O. Address *Brown*

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.