

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016171

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 6150 Registrar's No. 34

AMENDED

FILED MAY 10 1961

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NEW LISBON TWP</u>		Length of stay in 1b <u>3 yrs</u>	c. CITY OR TOWN <u>R#2, Bloomfield</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R#2, Bloomfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>NEW LISBON TWP.</u>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MILES</u> Middle <u>LIKE</u> Last <u>LIKE</u>			4. DATE OF DEATH Month <u>Apr.</u> Day <u>29</u> Year <u>1961</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-74</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>Stoddard Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>JAMES K. LIKE</u>	13b. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>MIRTLE LIKE</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 Address <u>Mrs. Oma Fisher, Bloomfield, Mo.</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Uremia</u>		<u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic glomerulo-nephritis</u>	<u>2 years</u>
	DUE TO (c) <u>Arteriosclerosis</u>	<u>10 yrs approx</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was pregnant <u>pregnant</u> was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u>11:50 P.</u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u>June 1960</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	STATE
21. I attended the deceased from <u>June 1960</u> to <u>April 29 1961</u> and last saw her alive on <u>April 29, 1961</u> Death occurred at <u>11:50 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>Dr. M. V.</u>	22b. ADDRESS <u>Stoddard Mo</u>	22c. DATE SIGNED <u>5/4/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-1-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>Stoddard Co. Mo.</u>

24. FUNERAL DIRECTOR <u>Wm H. Morgan, Advance, Mo</u>	ADDRESS <u>5-5-61</u>	25. DATE RECD. BY LOCAL REG. <u>5-5-61</u>	26. REGISTRAR'S SIGNATURE <u>Delma V. Jenkins</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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

W^m H. Morgan

Licensed Embalmer No. *0464*

P. O. Address *Advance, 1*

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.