SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-018543
STATE FILE NUMBER

AMENDED

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 59

FILED MAY 17 1961

1. PLACE OF DEATH
a. COUNTY PIKE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY PIKE

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LOUISIANA. Length of stay in 1b 1 wk.

c. CITY OR TOWN CLARKSVILLE Inside Limits Yes ☐ No ☒

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PIKE Co HOSPITAL Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) RR#4 Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First JAMES Middle FRANKLIN Last GOLLAHER

4. DATE OF DEATH Month MAY Day 7 Year 61

5. SEX MALE

6. COLOR OR RACE WHITE

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 11-11-1886

9. AGE (last birthday) 74.

IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10b. KIND OF BUSINESS OR INDUSTRY FAMING

11. BIRTHPLACE (City and state or country) WARSAW, ILL.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME JOHN H. GOLLAHER

13b. MOTHER'S MAIDEN NAME LURINDA ANN SHADE

14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. NONE

17. INFORMANT MRS. IDA WALLACE, Address CLARKSVILLE MISSOURI

MEDICAL CERTIFICATION

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)	Circulatory Failure (Heart block)	2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Decompensated Hypertensive Heart Disease	unknown
DUE TO (c)	Advanced Arteriosclerosis	unknown

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 female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1-28-61 to 5-7-61 and last saw ~~him~~ alive on 5-7-61

Death occurred at 9:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Per J. Brolinson (Degree or title) DO.

22b. ADDRESS 218 N. 5th St Louisiana Mo.

22c. DATE SIGNED 5-9-61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE MAY 9. 1961

23c. NAME OF CEMETERY OR CREMATORY CANTON CEM

23d. LOCATION (City, town, or county) CANTON (State) MO

24. FUNERAL DIRECTOR E.A.M. COLLIER

ADDRESS LOUISIANA

25. DATE RECD. BY LOCAL REG. May 9-61

26. REGISTRAR'S SIGNATURE Bernice Collier

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

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_____ Signed Geo. M. Collier

Signature of Student Embalmer

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.