MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-005860
STATE FILE NUMBER

AMENDED

Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 52

FILED FEB 19 1962

1. PLACE OF DEATH
a. COUNTY: Cedar
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: El Dorado Springs
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Cedar Mem; Hosp;
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Cedar
c. CITY OR TOWN: El Dorado Springs
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location):
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: John Middle: J. Last: Pace
4. DATE OF DEATH: Month February Day 10 Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 7/31/82
9. AGE (last birthday): 79
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): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St. Clair County Mo; USA
12. CITIZEN OF WHAT COUNTRY:
13a. FATHER'S NAME: Michael Pace
13b. MOTHER'S MAIDEN NAME: Martha Francis
14. NAME OF HUSBAND OR WIFE: Naida Pace
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Naida Pace, Address: El Dorado Springs Mo;

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Bronchial asthma
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 2-3-62 to 2-10-62 and last saw her/him alive on 2-10-62
Death occurred at 1:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert L. Magee M.D.
22b. ADDRESS: El Dorado Springs Mo;
22c. DATE SIGNED: 2/12/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/12/62
23c. NAME OF CEMETERY OR CREMATORY: Holsapple
23d. LOCATION (City, town, or county) (State): Collins Missouri
24. FUNERAL DIRECTOR ADDRESS: Goodrich Funeral Home, Osceola Mo.
25. DATE RECD. BY LOCAL REG.: 2/13/1962
26. REGISTRAR'S SIGNATURE: Joe E. Dunlap, Act. Registrar

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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 F B Goodrich

Signature of Student Embalmer

Licensed Embalmer No. 3038

P. O. Address Oscesee 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.