

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-012727

STATE FILE NUMBER

*Dr Martin*  
DO NOT WRITE ON THIS STUB

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 42

**FILED APR 3 1963**

1. PLACE OF DEATH a. COUNTY <b>Pike</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Pike</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Louisiana</b>		Length of stay in Td <b>9 days</b>	c. CITY OR TOWN <b>Louisiana, Mo.</b> 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>Pike County Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>603 Alabama</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>OSCAR</b>			4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1963</b>		
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>3-2-11</b>	9. AGE (last birthday) <b>52</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (City and state or country) <b>Busch, Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Early</b>		13b. MOTHER'S MAIDEN NAME <b>Minerva Hess</b>		14. NAME OF HUSBAND OR WIFE <b>Cora Mae Early</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Cora Mae Early</b> Address		

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)	<b>Cardiac Failure</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<b>5 months</b>
	DUE TO (c)	

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 <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 <b>Louisiana, Mo</b>	COUNTY	STATE
21. I attended the deceased from <b>Jan 1963</b> to <b>3-24-63</b> and last saw <sup>him</sup> alive on <b>3-24-63</b> . Death occurred at <b>12:20PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <b>W. Joe Martin, M.D.</b>		22b. ADDRESS <b>Louisiana, Mo.</b>	22c. DATE SIGNED <b>3-26-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-26-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Riverview</b>	23d. LOCATION (City, town, or county) (State) <b>Louisiana, Mo</b>

24. FUNERAL DIRECTOR <b>Collier Funeral Home, Louisiana, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-26-63</b>	26. REGISTRAR'S SIGNATURE <b>Bernice Collier</b>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59  
1 **0822**  
2 **0822**  
3  
4 **0**  
5 **1**  
6  
7 **0**  
8 **2**  
9 **1621**  
10  
11  
12 **1-0**  
13 **2-0**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

**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

*Geo M. Collier*

Licensed Embalmer No.

*3839*

P. O. Address

*Louisa, 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.