

Health,
Welfare
Public
Service

FILED JAN 27 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1064

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. x218 Registrar's No. 699

300
-57

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Windsor</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Windsor</u> 0420 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rock Island Addition</u>		Length of stay in 1b <u>45 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>404 E. Jackson St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Marvin</u> Middle <u>R.</u> Last <u>Oakes</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>8,</u> Year <u>1958</u>		
5. SEX <u>Male</u> <input checked="" type="checkbox"/>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-10-1884</u>	9. AGE (In years less birthday) <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rt. Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Benton Co, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Henry Oakes</u>		13b. MOTHER'S MAIDEN NAME <u>Mary McIntire</u>		14. NAME OF HUSBAND OR WIFE <u>May Carter</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>497-34-3724</u>		17. INFORMANT <u>Mrs. Earl Smith</u> Address <u>1539 S. Fremont Springfield, 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 Failure.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-8-58</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary occlusion.</u>			
DUE TO (c)			
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.) <u>4201</u>		
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.					

20d. INJURY OCCURRED WHILE AT <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>January 8, 1958</u> to <u>Jan. 8, 1958</u> and last saw her/him alive on <u>Jan. 8, 1958</u> on the date stated above; and to the best of my knowledge, from the causes stated. Death occurred at <u>3:30 p.</u>					

22a. SIGNATURE <u>Robert Windsor</u> (Degree or title)		22b. ADDRESS <u>Windsor Mo</u>		22c. DATE SIGNED <u>1-15-58</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-12-1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Oak Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Windsor, Mo.</u>	
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24. FUNERAL DIRECTOR <u>Ellis Huston</u> ADDRESS <u>Windsor, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-18-58</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Clifford Gouge*

Licensed Embalmer No. *5014*
P. O. Address *Windsor, 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.