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FILED AUG 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29099

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 157

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY OR TOWN Marshall, Mo.	c. LENGTH OF STAY (In this place) 53 days	c. CITY OR TOWN Marshall 0972	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbons Hospital		d. STREET ADDRESS (If rural, give location) 342 North Lafayette	

3. NAME OF DECEASED (Type or Print)	a. (First) Mortimer	b. (Middle) Gaines	c. (Last) Piper	4. DATE OF DEATH (Month) (Day) (Year) August 14 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH February 8-1898	9. AGE (In years last birthday) 57	10 UNDER 1 YEAR 6	10 UNDER 1 MONTH 6	10 UNDER 1 HOUR 6	10 UNDER 1 MIN. 6
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trained Saddle Horses-Owned Horses	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Marshall-Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John M. Piper	13b. MOTHER'S MAIDEN NAME Betty Elsea Piper	14. NAME OF HUSBAND OR WIFE Never Married
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes 1st World War	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. William Callis-Marshall, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		1901	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug 10, 1950**, to **Aug 14, 1950**, that I last saw the deceased alive on **Aug 14, 1950**, and that death occurred at **4:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John R. Lawrence M.D.	23b. ADDRESS Marshall, Mo.	23c. DATE SIGNED Aug 16-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/17/50	24c. NAME OF CEMETERY OR CREMATORY Ridge Park Cem	24d. LOCATION (City, town, or county) (State) Marshall, Missouri
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DATE REC'D BY LOCAL REG. Aug 16-1950	REGISTRAR'S SIGNATURE Bridney J Gray	25. FUNERAL DIRECTOR'S SIGNATURE J. Leslie Swenson	ADDRESS Marshall, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 8-21
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 8-21-50

AUG 30 1951

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *J. Lealie Surrency*

Licensed Embalmer No. 3235

P. O. Address *Marshall*

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 this body is not embalmed, fact should be so stated above.