

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20973**

FILED AUG 5 - 1955

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

BIRTH NO. _____		REG. DIST. NO. 4		PRIMARY REG. DIST. NO. 1414		Registrar's No. 54	
1. PLACE OF DEATH a. COUNTY Atchison				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE Missouri b. COUNTY Atchison			
b. CITY (If outside corporate limits, write RURAL and give town) Fairfax		c. LENGTH OF STAY (in this place) 16 hrs		c. CITY (If outside corporate limits, write RURAL and give township) Rock Port.		0030	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Fairfax Community Hosp.				d. STREET ADDRESS (If rural, give location) none			
3. NAME OF DECEASED (Type or Print) a. (First) Oscar			b. (Middle) Wilson		c. (Last) Savage		4. DATE OF DEATH (Month) (Day) (Year) 8-2-1955
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 3-4-1905	9. AGE (In years last birthday) 50		# UNDER 1 YEAR Months 4 Days 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Harrisenville, Mo.,		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME Myron Savage			13b. MOTHER'S MAIDEN NAME Lena Mc Ciure		14. NAME OF HUSBAND OR WIFE Mary Savage		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes unknown		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mrs Mary Savage, Rock Port. Mo.			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Pituitary Adenoma DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 24 hours 10 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		195x	
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 May , 1954, to Aug 2 , 1955, that I last saw the deceased alive on 8-2 , 1955, and that death occurred at 10:15 AM. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Wallace Carpenter M.D.				23b. ADDRESS Rock Port Mo.		23c. DATE SIGNED 8-2-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-4-1955		24c. NAME OF CEMETERY OR CREMATORY Hunter Cem		24d. LOCATION (City, town, or county) (State) Rock Port. Mo.,	
DATE REC'D BY LOCAL REG. Aug 4, 1955		REGISTRAR'S SIGNATURE Thoson		25. FUNERAL DIRECTOR'S SIGNATURE Bartholemew Mortuary		ADDRESS Rockport.	

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
Student Embalmer

Signed Gray Bartholomew

Licensed Embalmer No. 3173

P. O. Address Rock Port. 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 this body is not embalmed, fact should be so stated above.