

FILED NOV 14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35617

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 214

1. PLACE OF DEATH
a. COUNTY Saline
b. CITY OR TOWN Marshall
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbons Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE No. b. COUNTY Saline
c. CITY OR TOWN R. F. D. No. 3, Slater, Mo.
d. STREET ADDRESS (If rural, give location) 0970

3. NAME OF DECEASED (Type or Print)
a. (First) John b. (Middle) Abner c. (Last) Page

4. DATE OF DEATH (Month) (Day) (Year)
Nov. 3-1955

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH July, 3-1893

9. AGE (In years last birthday) 62

UNDER 1 YEAR Months 3

UNDER 100 HOURS Days 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY active

11. BIRTHPLACE (State or foreign country) Saline Co. Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME J. A. Page

13b. MOTHER'S MAIDEN NAME Eva D. Allen

14. NAME OF HUSBAND OR WIFE Nola Page

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no

16. SOCIAL SECURITY NO. (If yes, give way or date of service) no

17. INFORMANT'S SIGNATURE OR NAME Mrs. Nola Page, ADDRESS Slater, 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull fracture & cerebral concussion + hemorrhage.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fractures of 1, 2, 3, 4 Cervical vertebra.
II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death. 9/21

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 3

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm

21c. (CITY, TOWN, OR TOWNSHIP) Cambridge, Saline Mo. (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-1-55-AP. m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? Fall from tractor and ran over by corn picker.

22. I hereby certify that I attended the deceased from Nov. 1, 1955, to Nov. 3, 1955, that I last saw the deceased alive on Nov. 3, 1955, and that death occurred at 9:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. A. McBurney M.D.

23b. ADDRESS Slater, Mo.

23c. DATE SIGNED 11/5/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11/5/1955

24c. NAME OF CEMETERY OR CREMATORY City Cemetery

24d. LOCATION (City, town, or county) Slater, Mo. (State)

DATE REC'D BY LOCAL REG. NOV. 9. 55

REGISTRAR'S SIGNATURE Cecil G. Bob Deputy

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill Bros Slater, Mo.

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

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 _____

A. C. Hill

Licensed Embalmer No. *3090*

P. O. Address *Staten, 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.