

FILED JUL 13 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19535

STATE FILE NUMBER

Registration District No. 27 Primary Registration District No. 3005 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY <u>Bates Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wheeler</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BUTLER</u>		c. CITY OR TOWN <u>Harwood mo. 80</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Butler Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>RT 1</u>	
Length of stay in lb <u>15 Days</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>OLIVER</u>			4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>56</u>		
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>March 27 1888</u>		
9. AGE (In years last birthday) <u>68</u>			IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (City and state or country) <u>Cedar Co. mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. It.</u>		
13. FATHER'S NAME <u>Oliver Peterie</u>			14. MOTHER'S MAIDEN NAME <u>Mary Bates</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Charville Peterie</u>			Address <u>Butler RT 3</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>BRONCHO-PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> KNOWN FOR <u>6 MONTHS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CHRONIC LYMPHOCITIC LEUKEMIA</u>	
	DUE TO (c) <u>2040</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC PULMONARY EMPHYSEMA</u>		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 <u>1</u> Month <u>7</u> Day <u>1</u> a. m. <u>1</u> 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 COUNTY STATE

21. I attended the deceased from APRIL 4, 1954 to JULY 1, 1956 and last saw him alive on JULY 1, 1956.
Death occurred at 3:48 P. 3 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John M. Cooper M.D.</u>		22b. ADDRESS <u>BUTLER, MO.</u>		22c. DATE SIGNED <u>7-2-56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7-3-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Love Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Cedar Co. mo.</u>		
24. FUNERAL DIRECTOR <u>Swain-Creath Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>July 3-1956</u>		26. REGISTRAR'S SIGNATURE <u>Russell Korum</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

E. Edwards 777 170

(Licensed Embalmer's Statement)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Floyd E. Causthick*.....

Licensed Embalmer No. *44*

P. O. Address *.....*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.