

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 11 1957

57022147  
STATE LICENSE NUMBER

Registration District No. 277 Primary Registration District No. 411 Registrar's No. 33

300  
-57  
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1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LINCOLN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BOWLING GREEN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>WHITESIDE</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOME</u>		Length of stay in 1b	d. STREET ADDRESS <u>0570</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY ALLEN RECTOR</u>			4. DATE OF DEATH Month Day Year <u>JUNE 24, 1957</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>FEB 13, 1870</u>		9. AGE (In years last birthday) <u>87</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR - THRESHING MACHINE &amp; SAWMILL</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>GEO. W. RECTOR</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH HADDOCK</u>		
13c. NAME OF HUSBAND OR WIFE <u>ADA LEE RECTOR (DECEASED)</u>		14. NAME OF HUSBAND OR WIFE <u>ADA LEE RECTOR (DECEASED)</u>		14. NAME OF HUSBAND OR WIFE <u>ADA LEE RECTOR (DECEASED)</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>NONE</u>		17. INFORMANT <u>MRS HOWARD TEAGUE, WHITESIDE, 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>Cerebral anoxia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>76 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUPLICATE TO (b) <u>Cerebral Thrombosis</u>	
	DUPLICATE TO (c) <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332x</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 a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	

20e. 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 <u>WHITESIDE</u>	COUNTY <u>LINCOLN</u>	STATE <u>MO</u>
21. I attended the deceased from <u>6/22/57</u> to <u>6/24/57</u> and last saw her alive on <u>6/22/57</u> Death occurred at <u>11:30</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Ralph H. Snyder P.O.</u> (Degree or title)	22b. ADDRESS <u>519 W. Main Bowling Green Mo.</u>	22c. DATE SIGNED <u>6/28/57</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>DURIAL</u>	23b. DATE <u>JUNE 26, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MILL CREEK CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>LINCOLN Co., MO.</u>
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24. FUNERAL DIRECTOR <u>GEO. M. COLLIER, LOUISIANA, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>7/2/57</u>	26. REGISTRAR'S SIGNATURE <u>Bill Robinson</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.

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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 *Geo. M. Collier* .....

Licensed Embalmer No. *3839* .....

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

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.