

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011038
STATE FILE NUMBER

FILED MAR 21 1958

Registration District No. 278 Primary Registration District No. 5953 Registrar's No. 44

820
300
-57

1. PLACE OF DEATH a. COUNTY <u>Pike</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Buffalo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Louisiana</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>W.D. One Life</u>		Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>W.D. One</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IRA</u> Middle <u>GUY</u> Last <u>OLIVER</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 7, 1888</u>	
9. AGE (In years) <u>69</u>		IF UNDER 1 YEAR Months <u>07</u> Days <u>07</u>		IF UNDER 24 HRS. Hours <u>07</u> Min. <u>00</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 <u>Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Louisiana, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel Oliver</u>			13b. MOTHER'S MAIDEN NAME <u>Cynthia Kroome</u>			14. NAME OF HUSBAND OR WIFE <u>Alma D. Oliver</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>488-24-8789</u>		17. INFORMANT Address <u>MRS. ALMA D. OLIVER, LOUISIANA, 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>Coronary Artery Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Paralysis Agitan</u>		10-12 yrs			
		DUE TO (c) <u>Arteriosclerotic hypertensive cardiovascular disease</u>		15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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.) <u>---</u>				
20c. TIME OF INJURY Hour <u>---</u> Month <u>---</u> Day <u>---</u> Year <u>---</u> a.m. <u>---</u> p.m. <u>---</u>			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> 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.) <u>---</u>		20f. CITY, TOWN, OR LOCATION <u>---</u>		COUNTY <u>---</u>		STATE <u>---</u>	
21. I attended the deceased from <u>July 1956</u> to <u>March 8, 1958</u> last saw ^{her} him alive on <u>2/22/58</u> Death occurred at <u>2:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Chas. H. Remelder M.D.</u>				22b. ADDRESS <u>Louisiana, Missouri</u>		22c. DATE SIGNED <u>3/15/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Mar. 11, 1958</u>		23b. DATE <u>Mar. 11, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Buffalo Cem. Louisiana, Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>Louisiana, Mo.</u>	
24. FUNERAL DIRECTOR <u>Geo. M. Collier, Louisiana, Mo.</u>		ADDRESS <u>---</u>		25. DATE RECD. BY LOCAL REG. <u>March 15, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Berniece Collier</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. Callie

Licensed Embalmer No. *383*

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.