

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033780
STATE FILE NUMBER

FILED SEP 17 1958 Registration District No. 277 Primary Registration District No. 411 Registrar's No. 49

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Pike</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Pike</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>Bowling Green</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Length of stay in 1b | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

| | | | | | |
|--|----------------------------------|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Quarence Rudolph Falik</u> | | | 4. DATE OF DEATH Month Day Year <u>Sept. 9 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>Feb 24 1904</u> | | 9. AGE (In years last birthday) <u>54</u> UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAWYER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Stamps KY</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13a. FATHER'S NAME <u>OTO FALIK</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARGARET LINDHE</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Adina Falik</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>1106 Adina Falik</u> | |
| 17. INFORMANT <u>Bowling Green 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> DUE TO (b) <u>Cerebral emboli</u> DUE TO (c) <u>Coronary fibrillation 4331</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Previous cerebral emboli 2 yrs prior</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>years</u> | |

| | | | | | |
|---|--|---|--|--------------|--|
| 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 Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT <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 _____, to _____ and last saw ^{him} _{her} alive on 9-8-58
Death occurred at 3:15 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

| | | | | | |
|--|--|---|--|--|--|
| 22a. SIGNATURE <u>Robert A. Brubaker D.O.</u> (Degree or title) | | 22b. ADDRESS <u>Bowling Green, Mo</u> | | 22c. DATE SIGNED <u>9-10-58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>SEPT 11 1958</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Bowling Green</u> | |
| 23d. LOCATION (City, town, or county) <u>Bowling Green, Mo</u> | | 23e. DATE RECD. BY LOCAL REG. <u>9-12-58</u> | | 23f. REGISTRAR'S SIGNATURE <u>Gill Robinson</u> | |

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

SEP 24 1958

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 *Harold C. Kinde*

Licensed Embalmer No. *43-97*

P. O. Address *Bowling Green*

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.