

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038788
STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 251

1. PLACE OF DEATH a. COUNTY <u>Couchman</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Merics</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Centralia</u> ⁰¹⁰⁰	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>Couchman Co. Hosp</u> Length of stay in lb <u>1 Week</u>		d. STREET ADDRESS (If outside, give location) <u>210 E. Railroad</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IRA</u> Middle <u>RICHARD</u> Last <u>VANSKIKE</u>			4. DATE OF DEATH <u>NOV-14-1958</u> Month <u>Nov</u> Day <u>14</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>July-10-1897</u> Month <u>July</u> Day <u>10</u> Year <u>1897</u>
9. AGE (In years last birthday) <u>61</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Blair Route Mail Carrier</u>	11. BIRTHPLACE (City and state or country) <u>Macon County Mo</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Robert Vanskike</u>		14. MOTHER'S MAIDEN NAME <u>Susan E. Brock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>War No. 1</u>		16. SOCIAL SECURITY NO. <u>?</u> INFORMANT <u>Mrs. Alice Vanskike</u> Address <u>Centralia Mo</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small intestinal fistula due to intestinal obstruction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 weeks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic lymphatic leukemia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 <u>2/7/58</u> to <u>11/14/58</u> and last saw her/him alive on <u>11/14/58</u> Death occurred at <u>H 20 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Port L. Ward MD</u> (Degree or title)		22b. ADDRESS <u>Centralia Mo</u>	22c. DATE SIGNED <u>11/14/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Nov-16-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Moberly Missouri</u>
24. FUNERAL DIRECTOR <u>Cater Funeral Home</u> ADDRESS <u>Moberly Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Nov 14-1958</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>	

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 Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 PORT & WARD M.D.

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MAR 3 1959

STATEMENT BY LICENSED EMBALMER

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

Student.....
Signature of Student Embalmer

Signed..... *R. M. Cater*.....

Licensed Embalmer No. *47*

P. O. Address *Proberly*

- 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.