

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013038

STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 128

Primary Registration District No. 2

Registrar's No. 390A

S. 300
1-57

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

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>GREENE</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ash Grove</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Ash Grove</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boone Twp</u>			Length of stay in lb <u>Lifetime</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>LEMMON</u> Last <u>PIPER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1959</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>Aug. 19, 1880</u>		9. AGE (In years last birthday) <u>78</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
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>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Ash Grove, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>D. W. Piper</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Smith Perryman</u>			14. NAME OF HUSBAND OR WIFE <u>Ercie Piner</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>495-40-7063</u>		17. INFORMANT <u>Ercie Piper</u>			Address <u>Ash Grove, Missouri</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>Acute toxemia</u> DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Adenocarcinoma of stomach.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>First symptom 3-1-59</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 _____ a.m. _____ p.m. Month, Day, Year _____									
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>3-1-59</u> to <u>4-12-59</u> and last saw <u>her</u> alive on <u>4-12-59</u> Death occurred at <u>3:10</u> <u>A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Homer F. Matz, D.O.</u>				22b. ADDRESS <u>Ash Grove, Missouri</u>			22c. DATE SIGNED <u>4-13-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Apr. 14, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ash Grove Cemetery</u>		23d. LOCATION (City, town, or county) <u>Ash Grove</u>		(State) <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>BRIM DANIEL</u> <u>Brim & Daniel</u>			ADDRESS <u>Ash Grove, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-21-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie B. Melton</u>		

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 *Walter L. Samuel*

Licensed Embalmer No. *4702*

P. O. Address *Adk. Brook - W*

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.