

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 16 1959

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STATE FILE NUMBER

Registration District No. 328 Primary Registration District No. 4485 Registrar's No. 41

ENDED

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfeld</u>	Length of stay in 1b <u>9 years</u>	c. CITY OR TOWN <u>Fairfeld</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>at home</u>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>SAMUEL</u> Last <u>GAGE</u>	4. DATE OF DEATH Month <u>Nov</u> Day <u>28</u> Year <u>1959</u>
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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>Nov 22, 1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>6</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <u>Electrician</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>	11. BIRTHPLACE (City and state or country) <u>Union County, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
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13a. FATHER'S NAME <u>John Gage</u>	13b. MOTHER'S MAIDEN NAME <u>Ellen Brennan</u>	14. NAME OF HUSBAND OR WIFE <u>Clara Jackson</u>
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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>Don't Know</u>	17. INFORMANT (Name and address) <u>John Wakerstein Fairfield Mo</u>
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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>Hypostatic pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Malnutrition</u>		years
	DUE TO (c) <u>Senility</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Very poor living condition</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year
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20d. 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	COUNTY	STATE
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21. I attended the deceased from First call after death and last saw her 12:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Delma C. Buckthorpe M.D. Health Officer</u>	22b. ADDRESS <u>Benton, Mo</u>	22c. DATE SIGNED <u>12-11-59</u>
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23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-29-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lightner Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Illmo, Missouri</u>
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24. FUNERAL DIRECTOR <u>Bigling & Sons</u>	ADDRESS <u>Illmo, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-12-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Fred Bigling</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

GENERAL'S

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Ollie Cam...

Licensed Embalmer No. 4490

P. O. Address Illmo, N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.