

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007506

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 179 Primary Registration District No. 5668 Registrar's No. 29

FILED MAR 4 1963

VS 300
Rev. 4/59

1 0570
2 05702
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4 0
5 2
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7 1
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9 332X
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12 86-2
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bedford CLARK</u>		Length of stay in 1b <u>1 yr</u>	c. CITY OR TOWN <u>Elsberry Mo.</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>Wells Nursing Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	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>Ivan</u> Middle <u>Edgar</u> Last <u>Page</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>24</u> Year <u>1963</u>
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>Apr. 25, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Laborer) Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Devises Kansas</u>	9. AGE (last birthday) <u>81</u> IF UNDER 1 YEAR Months <u>10</u> Days <u>1</u> Hours <u></u> Min. <u></u> IF UNDER 24 HR Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Page</u>		13b. MOTHER'S MAIDEN NAME <u>Apselfa Soverns</u>	
14. NAME OF HUSBAND OR WIFE <u>Olive Page</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Denzil C. Page</u> Address <u>El Monte Cal. 11243 E. Elliott</u>	
19. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary failure</u> DUE TO (b) <u>cerebral thrombosis</u> DUE TO (c) <u>cerebral arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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
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.)	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year: <u></u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>Feb. 24 1963</u> to <u>Feb. 24 1963</u> and last saw ^{her} him alive on <u>2-21-63</u> Death occurred at <u>5.00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Adrian Krebs MD</u>		22b. ADDRESS <u>1 Poy. Mo.</u>	
22c. DATE SIGNED <u>2/25/63</u> (State)		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>Feb 26, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Norcatur Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Norcatur Kansas</u>		24. FUNERAL DIRECTOR <u>D.W. Mc Coy Troy Mo</u> ADDRESS <u>3-26-1963</u>	
25. DATE RECD. BY LOCAL REG. <u>3-26-1963</u>		26. REGISTRAR'S SIGNATURE <u>Charlotte Leek</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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 _____ Signed D. W. McBoyle
Signature of Student Embalmer

Licensed Embalmer No. 3586
 P. O. Address Lady Ws

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 _____ Signed D. W. McBoyle
Signature of Student Embalmer

Licensed Embalmer No. 3586
 P. O. Address Lady Ws

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.