

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-018928

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 185 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0017
2 00102
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kirkville, Mo.		c. CITY OR TOWN Novinger, Mo.	
Length of stay in 1b 11 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Laughlin Hospital		d. STREET ADDRESS (If outside, give location) none	
3. NAME OF DECEASED (Type or print) Isaac Denton Pearce		4. DATE OF DEATH 5-22-1963	
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-4-1888
9. AGE (last birthday) 75		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) miner		10b. KIND OF BUSINESS OR INDUSTRY miner	
11. BIRTHPLACE (City and state or country) Putnam Co. Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William Pearce		13b. MOTHER'S MAIDEN NAME Mary Byers	
14. NAME OF HUSBAND OR WIFE Teresa Kavanaugh		17. INFORMANT Charles W. Pearce, Novinger, Mo.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary failure			INTERVAL BETWEEN ONSET AND DEATH 20-30 Mins.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Post-surgical hemorrhage & shock			24 hours
DUE TO (c) Surgery for prostatic hypertrophy			30 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Extensive coronary artery disease			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. SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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	
21. I attended the deceased from 5/18/63 to 5/22/63 and last saw her ^{her} _{him} alive on 5/22/63 Death occurred at 8:35 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Jack A. Hunter D.D.</i>		22b. ADDRESS Kirkville, Mo.	22c. DATE SIGNED 5.24.63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 26, 1963	23c. NAME OF CEMETERY OR CREMATORY Novinger, Mo.	23d. LOCATION (City, town, or county) (State) Novinger Cemetery
24. FUNERAL DIRECTOR ADDRESS Dee Riley Funeral Home 415 N. Franklin		25. DATE RECD. BY LOCAL REG. May 24, 1963	26. REGISTRAR'S SIGNATURE <i>Doris W. Ratliff</i>

Kirkville, Mo. *W.K. Jackson* (Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

0384105092

Jack A. Auster, D.O.

Print name May 24 1965
9 1

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 Wm K Jackson

Licensed Embalmer No. 3954

P. O. Address Kirkville Mo

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.