

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032788

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 176 Primary Registration District No. 5654 Registrar's No. 14

STATE FILE NUMBER

**FILED AUG 26 1963**

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Miller</u>		c. CITY OR TOWN <u>Mt. Vernon</u>	
Length of stay in 1b <u>15 min</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Dr. office</u>		d. STREET ADDRESS (If outside, give location) <u>R.F.D. #</u>	
Hospital or Institution		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Ida May Ohmstead</u>			4. DATE OF DEATH Month <u>8</u> Day <u>10</u> Year <u>1963</u>			
5. SEX <u>Female</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>6-3-1886</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months <u>2</u> Days <u>7</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Taragould Ark</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>						

13a. FATHER'S NAME <u>George Cherk</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Tankshley</u>		14. NAME OF HUSBAND <u>Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Russell Kirpatrick</u> Address <u>Mt. Vernon R.F.D.</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute circulatory failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
DUE TO (b) <u>Myocardial Infarction</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u></u>		

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		
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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.)			
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>		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 8-10-63 to 8-10-63 and last saw her alive on 8-10-63  
Death occurred at 12:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Hugh Baker MD</u>	22b. ADDRESS <u>Miller, Mo</u>	22c. DATE SIGNED <u>8-12-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-13-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grace Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>Edmond Okla.</u>
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24. FUNERAL DIRECTOR <u>L.H. Leiman</u>	ADDRESS <u>Miller, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8-14-1963</u>	26. REGISTRAR'S SIGNATURE <u>W.S. Burney</u>
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB  
 AMENDED  
 DATE AMENDED  
 1 0550  
 2 550  
 3  
 4 1  
 5 2  
 6  
 7 1  
 8 2  
 9 420.1  
 10  
 11  
 12 91-2  
 13 2-0  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ  
 USE BLACK INK OR TYPEWRITER RIBBON

AUG 28 1963

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.**