

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-044908

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 397

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0808

2 0800

3

4 0

5 2

6

7 0

8 2

9 4/500

10

11

12 1-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

FILED NOV 19 1963

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>PETTIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SEDALIA</u>		Length of stay in lb <u>6 DAYS</u>	c. CITY OR TOWN <u>GREEN RIDGE</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>Bothwell Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>GREEN RIDGE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS IRA PACE</u>			4. DATE OF DEATH Month Day Year <u>11-15-1963</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>3-31-1884</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR 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		11. BIRTHPLACE (City and state or county) <u>KNOXBORO, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>JOHN PACE</u>		13b. MOTHER'S MAIDEN NAME <u>SALLY MASON</u>		14. NAME OF HUSBAND OR WIFE <u>BUSSIE ELLIOTT PACE</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.		17. INFORMANT <u>RUTH CHADWICK - KANSAS CITY, MO</u>			Address <u>1108 W. 45th St</u>

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute congestive heart failure

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Arteriosclerosis and pulmonary fibrosis

DUE TO (c)

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.
 Yes No 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 s.m. p.m.	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 STATE

21. I attended the deceased from 11-6-63 to 11-15-63 and last saw him alive on 11-15-63
Death occurred at 3:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>G. L. Walter</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>500 West 16th, Sedalia, Mo.</u>		22c. DATE SIGNED <u>11-15-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-17-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hickory Point</u>	23d. LOCATION (City, town, or county) (State) <u>GREEN RIDGE MO</u>	
24. FUNERAL DIRECTOR <u>Paul M. Moore-La Monte Inc</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 16, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Francis J. Anderson</u>	

USE BLACK INK OR TYPEWRITER RIBBON

DEC 4 1963

JAN 3 1964

original when registration closed

STATEMENT BY LICENSED EMBALMER

original when registration closed

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 Paul M. Moore

Licensed Embalmer No. 3223

P. O. Address La Monte 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.