

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048653

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 288

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 24 1963

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
Rev. 4/59								
1 <u>0595</u>								
2 <u>0595</u>								
3 <u>2</u>								
4 <u>0</u>								
5 <u>1</u>								
6								
7 <u>0</u>								
8 <u>2</u>								
<u>9422.1</u>								
10								
11								
12 <u>86-0</u>								
13 <u>1-0</u>								

1. PLACE OF DEATH a. COUNTY <b>LIVINGSTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>LIVINGSTON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CHILLICOTHE</b>		Length of stay in 1b <b>22 YEARS</b>	c. CITY OR TOWN <b>CHILLICOTHE</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>SUSAN'S NURSING HOME</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>220 CALHOUN ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES NEWTON OAKES</b>			4. DATE OF DEATH Month Day Year <b>DECEMBER 18 1963</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/5/1891</b>
9. AGE (last birthday) <b>72</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED LABORER</b>	11. BIRTHPLACE (City and state or country) <b>BROWNING, MO.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. NAME OF HUSBAND OR WIFE <b>MAUDE BELLE SHIPP</b>	
13a. FATHER'S NAME <b>SAM OAKES</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT <b>ERNEST OAKES: CHILLICOTHE, MISSOURI</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Prostatic hypertrophy.</b>			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 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 <b>Oct 63</b> to <b>Dec 18 63</b> and last saw him alive on <b>Dec 17 - 63</b> Death occurred at <b>6:55 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Joseph F. Gale M.D.</b>		22b. ADDRESS <b>Chillicothe Mo</b>	22c. DATE SIGNED <b>12-19-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/20/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESTHAVEN CEMETERY</b>
23d. LOCATION (City, town, or county) (State) <b>CHILLICOTHE, MISSOURI</b>		24. FUNERAL DIRECTOR ADDRESS <b>NORMAN FUNERAL HOME: CHILLICOTHE, MO.</b>	
25. DATE RECD. BY LOCAL REG. <b>Dec. 19, 1963</b>		26. REGISTRAR'S SIGNATURE <b>Annalise Taylor</b>	

**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 Elton Norman

Licensed Embalmer No. 4036

P. O. Address CHILLICOTHE, MISSOURI

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.

*St. Gall*