

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-022835
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 757

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 7 1965

VS 300
Rev. 4/59

1 5117
2 5110
3
4 1
5 2
6
7 0
8 0
9 8
10
11
12 1-0
13 1-8

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Joseph</u> Length of stay in 1b OR TOWN <u>3 days</u>		c. CITY OR TOWN <u>Easton</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>St. Joseph's Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>—</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Tillie Pearl Pike</u>			4. DATE OF DEATH Month Day Year <u>July 1 1965</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>Nov. 2 1890</u>
9. AGE (last birthday) <u>74</u> IF UNDER 1 YEAR IF UNDER 24 HR		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (City and state or country) <u>St. Joseph Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas Carr</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Readnow</u>	
14. NAME OF HUSBAND OR WIFE <u>Elonzo W. Pike</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. <u>—</u>		17. INFORMANT Address <u>Alpha O. Pike - Gower Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>P.O. Fracture Rt hip</u> DUE TO (c) <u>—</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) <u>ASHD + Diabetes mellitus</u>			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 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 <u>June 19 61</u> to <u>7-1-65</u> and last saw ^{her} him alive on <u>7-1-65</u> . Death occurred at <u>7:15</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. L. Matherhead M.D.</u>		22b. ADDRESS <u>2603 Federal</u>	22c. DATE SIGNED <u>7-2-65</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-3-65</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Gower Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hixson Funeral Home - Gower MO</u>		25. DATE RECD. BY LOCAL REG. <u>July 6, 1965</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>

DOCUMENT

BY AFFIDAVIT OF J. L. Matherhead M.D.

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 7-2-65

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 Clarence E. Hipson

Licensed Embalmer No. 5122

P. O. Address Jawaer, 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.