

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037472

STATE FILE NUMBER

FILED OCT 28 1958

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 112

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300
1-57
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1. PLACE OF DEATH a. COUNTY <u>Ray</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Carrollton</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>Ray Co. Memorial</u>		Length of stay in 1b <u>3 hours</u>	d. STREET ADDRESS (If outside, give location) <u>1116 Park</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Earl</u> Last <u>Rearden</u>			4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1934</u>		9. AGE (In years last birthday) <u>24</u>
10a. USUAL OCCUPATION (Give kind of work done during past 12 months, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY?
<u>Truck Driver</u>		<u>Rock</u>	<u>Bogard, Mo.</u>		<u>U.S.A.</u>
13a. FATHER'S NAME <u>Perry A. Rearden</u>		13b. MOTHER'S MAIDEN NAME <u>Lena Mattox</u>		14. NAME OF HUSBAND OR WIFE <u>Shirley H. Rearden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>487-36-3343</u>	17. INFORMANT Address <u>Perry A. Rearden, Carrollton, 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>Intracranial pressure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Head injury</u> DUE TO (c) <u>Auto accident</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>auto as Truck accident</u>		
20c. TIME OF INJURY Hour <u>2</u> a.m. Month <u>10</u> Day <u>23</u> Year <u>58</u>					
20d. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 10</u>	20f. CITY, TOWN, OR LOCATION <u>West of Norborne, Ray Mo.</u>		COUNTY STATE
21. I attended the deceased from <u>10-23-58</u> to <u>10-23-58</u> and last saw him alive on <u>10-23-58</u> Death occurred at <u>7:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>M. D. Richmond</u> (Degree or title)			22b. ADDRESS <u>Carrollton, Mo.</u>		22c. DATE SIGNED <u>10-23-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<u>Burial</u>		<u>10/26/1958</u>	<u>Carroll Memory Gardens</u>		<u>Carrollton, Mo.</u>
24. FUNERAL DIRECTOR <u>Standley-Gibson, Carrollton, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>10-24-1958</u>	26. REGISTRAR'S SIGNATURE <u>Malul Jackson</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 James F. Gibson, Student Embalmer No. #572 working under my personal supervision.

Student James F. Gibson
Signature of Student Embalmer

Signed Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.