

FILED APR 7 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7987

BIRTH NO. 12551 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 324

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (in this place) 25 min	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield, 0396		d. STREET ADDRESS (If rural, give location) 222 S Hampton Ave
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital					
3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Junior c. (Last) Carrell			4. DATE OF DEATH (Month) (Day) (Year) March 31 1952		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 3-31-52	9. AGE (In years last birthday) —	IF UNDER 1 YEAR Months — Days — Hours — Min. 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Springfield, Mo.		12. CITIZEN OF WHAT COUNTRY? U
13a. FATHER'S NAME James Elliot Carrell		13b. MOTHER'S MAIDEN NAME Ruby Mae Coker		14. NAME OF HUSBAND OR WIFE None	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. —	17. INFORMANT'S SIGNATURE OR NAME Ruby Mae Carrell Spald Mo		ADDRESS Springfield Mo	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Birth Injury	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Probably Intracranial Hemorrhage due to prolonged labor in Diabetic Mother				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 7691			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-31**, 1952, to **3-31**, 1952, that I last saw the deceased alive on **3-31**, 1952, and that death occurred at **12:55 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Leman D. Brown M.D. 307 1/2 College		23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 4/3/52
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 4-3-52	24c. NAME OF CEMETERY OR CREMATORY Hazelwood	24d. LOCATION (City, town, or county) (State) Springfield Mo
DATE REC'D BY LOCAL REG. 4-3-52	REGISTRAR'S SIGNATURE James H. Amos, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE H.V. Smith ADDRESS 602 N. Jefferson	

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
Student Embalmer

Signed *Not Embalmed* _____

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 this body is not embalmed, fact should be so stated above.