

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31453

State File No.

FILED SEP 29 1953

BIRTH NO. _____ REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 5430 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Clair, Central</u>	c. LENGTH OF STAY (in this place) <u>4 mo.</u>	c. CITY OR TOWN <u>St. Clair</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) <u>0360 Rural Virginia Mines Road</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Joseph</u> b. (Middle) <u>Amos</u> c. (Last) <u>Carrico</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>9 22 1953</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1907</u>	9. AGE (In years last birthday) <u>46</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>4</u> Min. <u>20</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disabled for 7 yrs</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Hannibal Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>
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13a. FATHER'S NAME <u>James Carrico</u>	13b. MOTHER'S MAIDEN NAME <u>Epperson</u>	14. NAME OF HUSBAND OR WIFE <u>Ruby Carrico</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Ruby Carrico</u>	ADDRESS <u>St. Clair Mo. R.R.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Coronary Insufficiency</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>General Arteriosclerosis</u>		<u>Years</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>422-1</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 7-15-53 to 9-22-53, that I last saw the deceased alive on 7-21-53, 1953 and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. E. Kitchener M.D.</u>	23b. ADDRESS <u>St. Clair Mo</u>	23c. DATE SIGNED <u>9-22</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>9-24-</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hannibal Cemetery, Hannibal Mo</u>	24d. LOCATION (City, town, or county) (State) <u>Hannibal Mo</u>
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DATE REC'D BY LOCAL REG. <u>9-23-53</u>	REGISTRAR'S SIGNATURE <u>William C. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>William C. ...</u>	ADDRESS <u>St. Clair Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0.300
0.48

60

1

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 *Sherwood W. Kitchell*.....

Licensed Embalmer No. *38*

P. O. Address *St. Clair*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.