

S. No. 300
V. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36427**

0582
1

FILED OCT 26 1953

BIRTH NO. _____		REG. DIST. NO. <u>184</u>		PRIMARY REG. DIST. NO. <u>3038</u>		Registrar's No. <u>325</u>		
1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> <u>0582</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Brookfield</u>		c. LENGTH OF STAY (in this place) <u>8 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Brookfield</u> <u>0</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>320 S. Livingston St.</u>				d. STREET ADDRESS (If rural, give location) <u>320 S. Livingston St.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>NINA</u> b. (Middle) <u>CARMACK</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 19, 1953</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>		8. DATE OF BIRTH <u>Sept. 9, 1883</u>		
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 MRS. Hours _____ Mins. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Sullivan Co., Mo. 0</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>Reuben Fanning</u>		13b. MOTHER'S MAIDEN NAME <u>Isabel Goodwin</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. Alonzo Carmack</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>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>W. L. Carmack, Brookfield, Mo.</u>			
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* (a) <u>Cerebral Hemorrhage Epilepsy</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Malignant Hypertension</u> DUE TO (c) <u>General Arterio Sclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>5 yr.</u> <u>12 yrs +</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					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) <u>331 X</u>				
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 <u>April 22, 1949</u> , to <u>Oct 18, 1953</u> , that I last saw the deceased alive on <u>Oct 18, 1953</u> , and that death occurred at <u>2 P.</u> m., from the causes and on the date stated above.								
23a. SIGNATURE <u>Roy R. Haley</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Brookfield Mo</u>		23c. DATE SIGNED <u>10/19/53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct 20, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Catherine, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>10-20-53</u>		REGISTRAR'S SIGNATURE <u>Radine Stambaugh Reg.</u> <u>157-0</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wright Funeral Home, Brookfield, Mo.</u>				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, 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 this body is not embalmed, fact should be so stated above.