

FILED JUL 12 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18316**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 67

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Excelsior Springs Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>71. Kent St 6002</u>	

3. NAME OF DECEASED (Type or Print) <u>ROBERT</u>	a. (First)	b. (Middle) <u>CARNAHAN</u>	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>June 17, 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Unk</u>	8. DATE OF BIRTH <u>Unk</u>	9. AGE (In years) (last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Unk</u>	11. BIRTHPLACE (State or foreign country) <u>Unk</u>	12. CITIZEN OF WHAT COUNTRY? <u>Unk</u>
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13a. FATHER'S NAME <u>Unk</u>	13b. MOTHER'S MAIDEN NAME <u>Unk</u>	14. NAME OF HUSBAND OR WIFE <u>Unk</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unk</u>	16. SOCIAL SECURITY NO. <u>Unk</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records, Exc. Springs</u>	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>year</u> <u>year</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis General</u> DUE TO (c) <u>Hypertension</u>		
	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 <u>331 X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____ m.	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 6-7, 1954, to 6-17, 1954, that I last saw the deceased alive on 6-17, 1954, and that death occurred at 9:30 a.m., from the cause and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Charles B. Shubert M.D.</u>	23b. ADDRESS <u>Excelsior Springs, Mo.</u>	23c. DATE SIGNED <u>6-23-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6-19-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	24d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>6/23/54</u>	REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Claude Richard</u>	ADDRESS <u>Excelsior Springs, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MS AUG 27 1968

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 *Lindell K. Jarman*

Licensed Embalmer No. *4589*

P. O. Address *Excelsior Springs 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.