

FILED DEC 9 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36349

BIRTH NO.		REG. DIST. NO. 1		PRIMARY REG. DIST. NO. 3000		Registrar's No. 418	
1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Sullivan			
d. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		c. LENGTH OF STAY (in this place) 11 Days		c. CITY OR TOWN Winigan R # 1		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 Grim-Smith Memorial Hospital				e. STREET ADDRESS (If rural, give location) 1021			
3. NAME OF DECEASED (Type or Print) a. (First) Emalene b. (Middle) c. (Last) Carmack			4. DATE OF DEATH (Month) (Day) (Year) November 19, 1954				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 8-20-61	
9. AGE (In years last birthday) 93		IF UNDER 1 YEAR Months 2 Days 30		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during part of the life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and State or Foreign Country) Sullivan County, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Jacob Coffman			13b. MOTHER'S MAIDEN NAME Kazirah Carmack		14. NAME OF HUSBAND OR WIFE John B. Carmack		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carl Carmack Bartlesville, Okla			
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) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 1 hr. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) E9040 21 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fr week of east jaundice 2 mo.			
19a. DATE OF OPERATION Nov 12, 1954		19b. MAJOR FINDINGS OF OPERATION Fr week of east jaundice. Asplenic necrosis of head				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Winigan 105 Sullivan Mo.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 13, 1954 7:00 a.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Pt fell			
22. I hereby certify that I attended the deceased from Sept 13, 1954, to Nov 19, 1954, that I last saw the deceased alive on Nov 19, 1954, and that death occurred at 9:20 P.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Milton T. English M.D.				23b. ADDRESS 1010 Winigan, Mo		23c. DATE SIGNED Nov 20, 1954	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-23-54		24c. NAME OF CEMETERY OR CREMATORY Baker Cem		24d. LOCATION (City, town, or county) (State) North Salem Mo.	
DATE REC'D BY LOCAL REG. 11-23-54		REGISTRAR'S SIGNATURE Kate Lambert 1-0		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wade Funeral Home Browning, MO			

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Gerald I. Wa*.....

Licensed Embalmer No. *417*.....

P. O. Address *Brown*.....

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.