

FILED JAN 24 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1718

BIRTH NO.		REG. DIST. NO. 200	PRIMARY REG. DIST. NO. 5225	Registrar's No. 34
1. PLACE OF DEATH a. COUNTY Macon 0610		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Macon Parish	c. LENGTH OF STAY (In this place) 6mo 27da	c. CITY (If outside corporate limits, write RURAL and give township) Kirksville 0013		
d. FULL NAME OF HOSPITAL OR INSTITUTION Still Hildreth San.		d. STREET ADDRESS F (If rural, give location) 1		
3. NAME OF DECEASED (Type or Print) William Winfield Carper		a. (First)	b. (Middle)	c. (Last)
4. DATE OF DEATH (Month) (Day) (Year) 1 7 55				
5. SEX MO	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 12-19-1861	9. AGE (In years last birthday) 93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drugstore		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Virginia	12. CITIZEN OF WHAT COUNTRY? 1
13a. FATHER'S NAME Wm Carper		13b. MOTHER'S MAIDEN NAME Mayjane Taylor	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE AND NAME ADDRESS Dr. M. Blue Morby Kirksville	
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) Congestive Circulatory Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senile Psychosis DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Interval between onset and death: several years.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4500			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	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 June 10, 1954, to Jan 7, 1955, that I last saw the deceased alive on Jan 7, 1955, and that death occurred at 5:30 p.m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) A. P. Mauck L.D.O.		23b. ADDRESS Macon Mo		23c. DATE SIGNED 1-7-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-10-1955	24c. NAME OF CEMETERY OR CREMATORY Llewellyn	24d. LOCATION (City, town, or county) (State) Kirksville Mo.	
DATE REC'D BY LOCAL REG. 1-12-55	REGISTRAR'S SIGNATURE Ruth McNeely	FUNERAL DIRECTOR'S SIGNATURE J. Lester Bram		ADDRESS Macon, Mo.

(Licensed Emballer's Statement on Reverse Side)

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

RECEIVED 1-20-55  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 1-55-7  
Date Filed 1-22-55

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 R. Lester Brun

Licensed Embalmer No. 4472

P. O. Address Macon, 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.