

No. 300
10.48

FILED AUG 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21512

State File No.

BIRTH NO. _____ REG. DIST. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 73

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 town) <u>Excelsior Springs</u>	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <u>Excelsior Springs</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Excelsior Springs Hospital</u>		STREET ADDRESS (If rural, give location) <u>220 West Excelsior Street</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u>	b. (Middle) <u>J.</u>	c. (Last) <u>Carroll</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 1, 1955</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>Widowed</u>	8. DATE OF BIRTH <u>May 3, 1873</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Office Employee</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Worth County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Thomas Carroll</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Quinn</u>	14. NAME OF HUSBAND OR WIFE <u>Tabitha Carroll</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. <u>708-01-0857</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. W. C. Holtman, Wamego, Kansas</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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Shod - from fractured hip -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fractured Hip</u>		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>9036</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>44</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT, SUICIDE, HOMICIDE <u>Fractured hip - Barber Shop</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Barber Shop</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) <u>Excelsior Springs Clay</u> (STATE) <u>Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>7-30 1955 5^{PM}</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>fell in barber shop, striking tile floor</u>
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22. I hereby certify that I attended the deceased from 7-30, 1955, to 8-1, 1955, that I last saw the deceased alive on 7-30, 1955, and that death occurred at 7 A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. M. E. Cranden, M.D.</u>	23b. ADDRESS <u>Excelsior Springs Mo.</u>	23c. DATE SIGNED <u>8-3-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-4-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Conception Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Conception, Mo</u>
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DATE REC'D BY LOCAL REG. <u>8-3-55</u>	REGISTRAR'S SIGNATURE <u>Lettie Withers Deputy</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Claude Prichard, Excelsior Springs, Mo.</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

NOV 11 1934

OCT 24 1934

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 *Lindell Garrison*

Licensed Embalmer No. *45*
P. O. Address *Epelios Spring*

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.