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

FILED SEP 20 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30519

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 262

1. PLACE OF DEATH
a. COUNTY ST. FRANCOIS
b. CITY OR TOWN ST. FRANCOIS TOWNSHIP
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MINERAL AREA OSTEO. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE MISSOURI
b. COUNTY ST. FRANCOIS
c. CITY OR TOWN DOE RUN
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) THOMAS
c. (Last) CARTEE

4. DATE OF DEATH (Month) Sept. (Day) 8, (Year) 1955

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH 4-24-1882
9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months 4 Days 14 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) ST. FRANCOIS COUNTY, MO
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME JOSEPH CARTEE
13b. MOTHER'S MAIDEN NAME SARAH THOMPSON
14. NAME OF HUSBAND OR WIFE TRIXIE CARTEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 487-18-3015
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Trixie Cartee, Doe Run, Mo.

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH July 27, 1955

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

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 4201.
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 27, 1955, *to* Sept 8, 1955, *that I last saw the deceased alive on* Sept 8, 1955, *and that death occurred at* 10:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE L. M. Stanfield (Degree or title) D.O.
23b. ADDRESS Farmington Mo
23c. DATE SIGNED 9/8/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/8/55
24c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery
24d. LOCATION (City, town, or county) (State) Doe Run, Mo

DATE REC'D BY LOCAL REG. Sept. 9, 1955
REGISTRAR'S SIGNATURE Esther Rudloff
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Miller Funl Home, Farmington, Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. Paul K Dugal .....

Licensed Embalmer No. 4120

P. O. Address Farmington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.