

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32928

FILED SEP 18 1956

Registration District No. 359 Primary Registration District No. 4526 Registrar's No. 17

STATE FILE NUMBER

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH. a. COUNTY <u>VERNON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>VERNON</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SHELDON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SHELDON 1080</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b		d. STREET ADDRESS (If outside, give location)		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WILLIAM</u> Last <u>CARR</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>26</u> Year <u>1956</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 10, 1862</u>		9. AGE (In years last birthday) <u>94</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>BENTON ILL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOEL BROMFIELD CARR</u>				14. MOTHER'S MAIDEN NAME <u>MEADOWS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs Clara C. Allen</u>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 Days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Cerebral Hemorrhage</u>		DUE TO (c)		3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>331x</u>					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>July 2</u> to <u>July 26</u> and last saw ^{her} him alive on <u>Aug 26</u> Death occurred at <u>2 am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>L B Bannister MO</u>			(Degree or title)			22b. ADDRESS <u>Kenn Springs MO</u>		22c. DATE SIGNED <u>8-27-56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug 26-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sheldon Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>VERNON CO. MO</u>			
24. FUNERAL DIRECTOR <u>L. Bernard Burg Sheldon mo</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Sept 9 1956</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Ruth Faith</u>	

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 *S. Bernard Perry*.....

Licensed Embalmer No. *4118*

P. O. Address *Shelton*

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.