

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022725

STATE FILE NUMBER

FILED JUN 16 1958

Registration District No. 254 Primary Registration District No. 5867 Registrar's No. 31

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1. PLACE OF DEATH a. COUNTY <b>Oregon</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Oregon</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Thayer</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Thayer</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <b>21 years</b>	d. STREET ADDRESS (If outside, give location) <b>0750</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Frank</b> Last <b>Carpenter</b>			4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1895</b>		9. AGE (In years last birthday) <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Public Works</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Branson, Missouri</b>	
10c. CITIZEN OF WHAT COUNTRY? <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Carpenter</b>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <b>Ella Holt</b>		14. NAME OF HUSBAND OR WIFE <b>Ida Mae Carpenter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Ida Mae Carpenter, Thayer, Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>Spunde Cell y fibro sarcoma</del> <b>Spunde Cell y fibro sarcoma</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>of right shoulder &amp; left hip</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
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.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>1956</b> to <b>May 31, 1958</b> and last saw him alive on <b>May 31, 1958</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>1978</b>		
22a. SIGNATURE <b>W Cooper</b> (Degree or title) <b>MD</b>			22b. ADDRESS <b>Thayer</b>		
22c. DATE SIGNED <b>6-12-58</b>			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6-2-1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis State Line Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Fulton County, Arkansas</b>		23e. LOCATION (State)		23f. LOCATION (State)	
24. FUNERAL DIRECTOR <b>Glenn Carter</b>		25. DATE RECD. BY LOCAL REG. <b>6-13-1958</b>		26. REGISTRAR'S SIGNATURE <b>Arthur Wolff</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Alcohol, tobacco, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Richard Carter*

Licensed Embalmer No. *4511*  
P. O. Address *Hayes*

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.