

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036202

STATE FILE NUMBER

FILED OCT 28 1958

Registration District No. 140 Primary Registration District No. 3021 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fayette Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Fayette</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>S. Park Addn.</b>		Length of stay in lb <b>15 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>S. Park Addn.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARROLL LUSHER</b>			4. DATE OF DEATH Month Day Year <b>OCT. 15, 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/30/1889</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Dish Washer</b>	9c. AGE (In years last birthday) <b>68</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dish Washer</b>	11. BIRTHPLACE (City and state or country) <b>Randolph County, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Lusher</b>	
13b. MOTHER'S MAIDEN NAME <b>Cassie Emory</b>		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>499-24-3624</b>	17. INFORMANT <b>Lizzie Blake R. R. 2 Armstrong, Mo.</b> 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) <b>Cerebral Embolus</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>4522</b>			INTERVAL BETWEEN ONSET AND DEATH
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.)		
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. CITY, TOWN, OR LOCATION COUNTY STATE		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>10-15-58</b> to <b>10-15-58</b> and last saw <sup>her</sup> <del>him</del> <b>Frank</b> <b>10-15-58</b> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.		21. I attended the deceased from _____ to _____ and last saw <sup>her</sup> <del>him</del> _____ <b>Frank</b> <b>10-15-58</b> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>W. Bloom M.D. 3</b>	22b. ADDRESS <b>Fayette Mo</b>		22c. DATE SIGNED <b>10-20-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/17/1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Roanoke Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Roanoke, Missouri</b>
24. FUNERAL DIRECTOR <b>Joseph A. Carr</b> ADDRESS <b>Fayette, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-20-58</b>	26. REGISTRAR'S SIGNATURE <b>Mary K. Shell</b>	

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Donald L Roberts* .....

Licensed Embalmer No. *4722* .....

P. O. Address *Fayette, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.