

Health,  
Welfare  
Public  
Service

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FILED JAN 29 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001808  
STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 3030 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Festus</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Festus</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 <u>801 WAREN</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>801 WAREN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>J.</u> Last <u>CARRON</u>			4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>59</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 9, 1881</u>	9. AGE (In years, Last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTH PLACE (City and state or country) <u>Bloomsdale, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Ambrose Carron</u>		13b. MOTHER'S MAIDEN NAME <u>MARY PULLEN</u>	14. NAME OF HUSBAND OR WIFE <u>CLARA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Valle Carron, Crystal City, Mo</u>	

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>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (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) <u>Pulmonary tuberculosis (chronic fibroid type)</u>			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>4200A</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>4200A</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>Crystal City, Mo</u>	COUNTY _____	STATE _____
21. I attended the deceased from <u>6-1-1944</u> to <u>1-21-1959</u> and last saw <sup>her</sup> him alive on <u>1-20-1959</u> Death occurred at <u>5:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>John F. Rutledge</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>Crystal City, Mo.</u>		22c. DATE SIGNED <u>1-21-1959</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-23-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GAMEL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>Festus, Missouri</u>
24. FUNERAL DIRECTOR <u>Georg R. Palitta</u> ADDRESS <u>Crystal City</u>		25. DATE RECD. BY LOCAL REG. <u>1-21-59</u>	26. REGISTRAR'S SIGNATURE <u>Gene G. Reid</u>

(L) See Registrar's Statement on Reverse Side

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 27 1959

### 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 *Guastep R. Polito*  
Licensed Embalmer No. *348*  
P. O. Address *Crystal*

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.