

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006356

STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. _____ Registrar's No. 31

300
1-57

| | | | | | |
|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Macon</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon Hudson</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Macon</u> | | Inside Limits Yes <input 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) <u>Hiway 63 N.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Iva</u> Middle <u>FLORENCE</u> Last <u>CAREY</u> | | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1959</u> | | |
| 5. SEX <u>Female</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>Jan. 5, 1885</u> | 9. AGE (In years last birthday) <u>74</u> | IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u> IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Liberty Illinois</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>George Wheeler</u> | | 13b. MOTHER'S MAIDEN NAME <u>Emma Robb</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Robert F. Carey Sr.</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>Robert F. Carey Sr.</u> | | Address <u>Macon, Missouri</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>Tuberculosis Pulmonary</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>CO2X</u> | |
| INTERVAL BETWEEN ONSET AND DEATH <u>10 years.</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.) | | 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____ | | 20d. INJURY OCCURRED WHILE AT <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 <u>Macon, Missouri</u> | | COUNTY _____ STATE _____ | |
| 21. I attended the deceased from <u>1950</u> to <u>Feb 1959</u> and last saw her alive on <u>9 Feb 59</u> Death occurred at <u>10:06 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) <u>Donald E. Eggleston</u> | | 22b. ADDRESS <u>Macon, Missouri</u> | |
| 22c. DATE SIGNED <u>14 Feb 59</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>2-11-1959</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u> | | 23d. LOCATION (City, town, or county) <u>Atlanta</u> | | (State) <u>Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>R. Lester Brown</u> | | ADDRESS <u>Macon, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>2/19/59</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Ruth Mcneely</u> | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *R. Lester Brown*

Licensed Embalmer No. *4472*
P. O. Address *Mason, Ky*

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.