

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006554

STATE FILE NUMBER

FEB 24 1959

Registration District No. 264

Primary Registration District No.

Registrar's No. 12

300
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> | |
| b. CITY (If possible give corporate limits, give TOWNSHIP only) OR TOWN <u>Dora, Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN <u>Dora 0970</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rte 1</u> Length of stay in 1b <u>40 days</u> | | d. STREET ADDRESS (If outside, give location) <u>Rte 1</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Carlton Canada</u> | | | 4. DATE OF DEATH Month Day Year <u>2-13-59</u> |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-5-1894</u> |
| 9. AGE (In years last birthday) <u>64</u> | | 10. FUNDING YEAR <u>66</u> | 11. IF UNDER 24 HRS. Hours 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 <input checked="" type="checkbox"/> | 11. BIRTHPLACE (City and state or country) <u>Merced Co, Mo</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Wm Canada</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Joe Bergist</u> | | 14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT <u>Ruth Traysont</u> Address <u>unfilled no</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>Crony Cocaine</u> 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) _____ | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH <u>4201</u> | |
| 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 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 _____, to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Frank W. Berry</u> (Degree or title) | | 22b. ADDRESS <u>Cambridge Mo</u> | |
| 22c. DATE SIGNED <u>2-18-59</u> | | | |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>no</u> | | 23b. DATE <u>2-14-59</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Meelow</u> | | 23d. LOCATION (City, town, or county) (State) <u>Dora Mo</u> | |
| 24. FUNERAL DIRECTOR <u>Robertson, Mrs. Paul</u> ADDRESS <u>no</u> | | 25. DATE RECD. BY LOCAL REG. <u>2-19-59</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Theresa Madan</u> | | | |

All diseases in Part I must be causally related.

FEB 26 1959

MAR 30 1959

VS APR 3 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 *A. Roberts*

Licensed Embalmer No. *3427*
P. O. Address *West Hill*

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.