

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008186

STATE FILE NUMBER

FILED MAR 3 1959

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 28

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY OR TOWN Merada Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN Webb City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital # 362/100 Length of stay in 7b 8 1/2 Mo		d. STREET ADDRESS (If outside, give location) 808 North Oak St Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Levi's Lewis Carrer		4. DATE OF DEATH Month Day Year Feb 15, 1959	
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 24, 1919
9. AGE (In years last birthday) 39		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (City and state or country) Webb City, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Leri Carrer		13b. MOTHER'S MAIDEN NAME Mabel Redmond	
14. NAME OF HUSBAND OR WIFE [Redacted]		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. ---		17. INFORMANT ADM. PAPERS 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) Intestinal Obstruction, Acute DUE TO (b) Psychosis with Mental Deficiency DUE TO (c) 5706			INTERVAL BETWEEN ONSET AND DEATH 1-2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5706			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 o.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	
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 March 1, 1956 to Feb 15, 1959 and last saw him alive on Feb 15, 1959 Death occurred at 6:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George Carrer, M.D.		22b. ADDRESS State Hospital No. 3.	
22c. DATE SIGNED 2-15-59		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE Feb 18, 1959		23c. NAME OF CEMETERY OR CREMATORY Webb City Cem.	
23d. LOCATION (City, town, or country) (State) Webb City Mo		24. FUNERAL DIRECTOR ADDRESS Johnston-Arnce-Simpson Mortuary Webb City Mo	
25. DATE RECD. BY LOCAL REG. 2-24-1959		26. REGISTRAR'S SIGNATURE (Lina) J. Perry	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Harvey E. Ames

Licensed Embalmer No. *4462*

P. O. Address *Wen City*

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.