

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008293  
STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

300  
-57

FILED MAR 17 1959 Registration District No. 4 Primary Registration District No. \_\_\_\_\_ Registrar's No. 29

1. PLACE OF DEATH a. COUNTY <b>Atchison</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Holt</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fairfax</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Oregon</b> <i>0440</i> 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>Community Hospital</b>		Length of stay in lb <b>3 weeks</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWIN OSCAR CARROLL</b>			4. DATE OF DEATH Month Day Year <b>March 9, 1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1884</b>
9. AGE (In years last birthday) <b>74</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>Painter &amp; Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Oregon, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>James Carroll</b>	
13b. MOTHER'S MAIDEN NAME <b>Sarah French</b>		14. NAME OF HUSBAND OR WIFE <b>Lovina</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>487-34-9710</b>	17. INFORMANT Address <b>Russell Carroll, Oregon, Missouri</b>
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>Carcinoma left lung</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
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)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 COUNTY STATE
21. I attended the deceased from <b>July 1, 1953</b> to <b>Mar 9, 1959</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>Mar 9, 1959</b> Death occurred at <b>3 P. M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Gene F. Sullivan M.D.</b>		22b. ADDRESS <b>Oregon, Missouri</b>	22c. DATE SIGNED <b>3/9/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/11/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oregon Cemetery</b>
23d. LOCATION (City, town, or county) (State) <b>Oregon, Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>James H. Pettigrew Oregon, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>March 10, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Therwin N. Schuster</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in reporting cause of death. All diseases in Part I must be causally related.

0564 6 28 11,

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 *Samuel H. Pettijohn* .....

Licensed Embalmer No. *3192* .....

P. O. Address *Oregon 1960* .....

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.