

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009861  
STATE FILE NUMBER

FILED MAR 24 1959

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 151

300  
-57

1. PLACE OF DEATH a. COUNTY <b>JASPER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JASPER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JOPLIN</b>		c. CITY OR TOWN <b>JOPLIN</b> 04950	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>JOPLIN GENERAL HOSP.</b> 52 YRS		d. STREET ADDRESS (If outside, give location) <b>719 PEARL AVE.</b>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <b>CORA E. APPERGER CARROLL</b>			4. DATE OF DEATH Month Day Year <b>MARCH 8, 1959</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 16, 1881</b>
9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (City and state or country) <b>CASSVILLE, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>THOMAS B. WILLIAMS</b>		13b. MOTHER'S MAIDEN NAME <b>FRANCES ROBERTS</b>	
14. NAME OF HUSBAND OR WIFE <b>WALTER D. CARROLL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <b>NO</b> unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>492-36-1558</b>	
17. INFORMANT Address <b>WALTER D. CARROLL, 719 PEARL AVENUE</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>Congestive Circulatory Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Decompensated Hypertensive Heart Disease</b>			<b>2 Weeks</b>
DUE TO (c) <b>Arteriosclerosis</b>			<b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input checked="" 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 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 <b>Feb. 10, 1959</b> to <b>March 8, 1959</b> and last saw her alive on <b>March 8, 1959</b> Death occurred at <b>10:15 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>J. E. Stephan, M.D. 2</b>		22b. ADDRESS <b>211 W. 20th St., Joplin, Missouri</b>	
22c. DATE SIGNED <b>3-13-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3-11-59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE CEMETERY,</b>		23d. LOCATION (City, town, or county) (State) <b>WEBB CITY, MISSOURI</b>	
24. FUNERAL DIRECTOR ADDRESS <b>STEVE PARKER MORTUARY, JOPLIN, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>3-19-1959</b>	
26. REGISTRAR'S SIGNATURE <b>Dove Merriam</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 8 1958

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 *F. M. Jones* .....

Licensed Embalmer No. *2319* .....

P. O. Address *Joplin Mo* .....

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.