

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013210

STATE FILE NUMBER
1953

FILED MAY 13 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1953

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-57

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|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Mo. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas 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 D. O. A. Osteopathic Hosp. | | Length of stay in lb 59 1/2 | d. STREET ADDRESS (If outside, give location) Buckingham Hotel 31st & Forest Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Ethel Middle Carroll Last Carroll | | | 4. DATE OF DEATH Month 4 Day 19 Year 59 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 29 1884 |
| 9. AGE (In years by birthday) 74 | | IF UNDER 1 YEAR Months 7 Days 19 Hours 15 Min. 0 | IF UNDER 24 HRS Hours 15 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Clinton, Mo. |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13a. FATHER'S NAME Frank Spear | |
| 13b. MOTHER'S MAIDEN NAME Lamyra Hayes | | 14. NAME OF HUSBAND OR WIFE Perlie Carroll | |
| 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. 498 32 5285 | |
| 17. INFORMANT Perlie Carroll, K. C. Mo. | | 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) Acute heart failure DUE TO (b) Coronary artery occlusion DUE TO (c) Coronary artery sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4261 | | | INTERVAL BETWEEN ONSET AND DEATH 3 hrs. |
| 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 7:26 Month 4 Day 19 Year 59 a.m. a. 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 K. C. Mo | | 20g. COUNTY K. C. Mo | |
| 20h. STATE Mo | | 21. I attended the deceased from 11-12-55 to 4-19-59 and last saw her alive on 4-19-59 Death occurred at 7:26 a. m on the date stated above; and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE [Signature] (Degree or title) D.O. | | 22b. ADDRESS 11109 W. Main St. Ind | |
| 22c. DATE SIGNED 4-20-59 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | |
| 23b. DATE 4 21 59 | | 23c. NAME OF CEMETERY OR CREMATORY Elmwood | |
| 23d. LOCATION (City, town, or county) K. C. Mo | | 23e. STATE Mo | |
| 24. FUNERAL DIRECTOR D. W. McComer's Sons, Mo. | | ADDRESS K. C. | |
| 25. DATE RECD. BY LOCAL REG. 4-20-59 | | 26. REGISTRAR'S SIGNATURE Heva Minshall | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

E. O. Fisher

MEDICAL CERTIFICATION

ALL INFORMATION ON THIS CARD MUST BE CONTAINED HEREIN

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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 *Albert L. Savage*

Licensed Embalmer No. *4812*
P. O. Address *Haines C.*

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.