

Health, Welfare Public Service

FILED JUN 4 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019020

STATE FILE NUMBER

XC-2019 14 70

SL 19796

Registration District No. Primary Registration District No.

Registrar No. 5081

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BARRY</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND, ST LOUIS, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>WASHBURN</b>		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>VET. ADM. HOSPITAL</b>		Length of stay in 1b <b>27 DAYS</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 <b>FRANK</b> Middle <b>B.</b> Last <b>CARGILE</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>24</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 3 WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11-18-15</b>	9. AGE (In years last birthday) <b>43</b>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (City and state or country) <b>WASHBURN, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>WALTER CARGILE</b>		13b. MOTHER'S MAIDEN NAME <b>MARINDA BREWER</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES WW-II</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>VA HOSP. RECORDS, ST. LOUIS, MO.</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>VENTRICULAR FIBRILLATION</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 MINUTES</b>  <b>YEARS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					
DUE TO (c) <b>- 420.0 -</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ARTERIOSCLEROSIS OBLITERANS</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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>4-27-59</b> to <b>5-24-59</b> and last saw him alive on <b>5-24-59</b> Death occurred at <b>9:15 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i> <b>S. H. SHIELDS, M.D.</b> (Degree or title)		22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>		22c. DATE SIGNED <b>5/25/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5-27-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) (State) <b>Cassville, Mo.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe 4700 Washington, Blvd.</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>MAY 26 '59</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i> <b>Roan Smith, M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *J. W. B. Bursley* .....

Licensed Embalmer No. *3653* .....

P. O. Address *St. Louis 8 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.