

pt. Health,
 & Welfare
 S. Public
 Health Service

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

59-020291

STATE FILE NUMBER

FILED JUN 16 1959

Registration District No. 002

Primary Registration District No.

Registrar's No. 38

V. S. 300
 ev. 1-57

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
 All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Andrew		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Andrew	
b. CITY OR TOWN Bolekov Rural		c. CITY OR TOWN Bolekov Rural	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) Elmer		4. DATE OF DEATH Month 6 Day 12 Year 1959	
5. SEX male		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 4-14-1886	
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (City and state or country) Holt County Mo		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Samuel Karr		13b. MOTHER'S MAIDEN NAME Rancy Berry	
14. NAME OF HUSBAND OR WIFE Saddie Karr		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. none		17. INFORMANT ms. Saddle Karr Bolekov Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate, & DUE TO (b) Generalized Metastasis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 years & 6 months
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 _____ 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 8-25-58 to 6-12-59 and last saw her him alive on 6-5-59 Death occurred at 7:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Lillian B. Kelley MD (Signature or title)		22b. ADDRESS Savannah, Missouri	
22c. DATE SIGNED 6-12-59		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 6-15-59		23c. NAME OF CEMETERY OR CREMATORY Fillmore	
23d. LOCATION (City, town, or county) (State) Fillmore Mo		24. FUNERAL DIRECTOR Great Funeral Home Savannah Mo ADDRESS	
25. DATE RECD. BY LOCAL REG. 6-15-59		26. REGISTRAR'S SIGNATURE Lillian Sparks	

(Licensed Embalmer's Statement on Reverse Side)

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 *E. C. Breit*

Licensed Embalmer No. *2650*

P. O. Address *Sacramento*

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.