

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020652

STATE FILE NUMBER

FILED JUN 23 1959 Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 45

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Carrollton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Carrollton</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Atwood Hospital</b>		Length of stay in 1b <b>17 years</b>	d. STREET (If outside, give location) ADDRESS <b>307 W. 2<sup>nd</sup> St.</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MILFORD</b> Middle <b>ROBERT</b> Last <b>ELLIOTT</b>			4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>Dec. 24, 1911</b>	9. AGE (In years last birthday) <b>47</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Independent trucker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Gasoline</b>	11. BIRTHPLACE (City and state or country) <b>Marion, Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>E.E. Elliott</b>	13b. MOTHER'S MAIDEN NAME <b>Vida Barrett</b>	14. NAME OF HUSBAND OR WIFE <b>Paola Elliott</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>487-12-8391</b>	17. INFORMANT Address <b>Mrs. Milford Elliott, Carrollton, Mo.</b>
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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>Coronary Occlusion &amp; Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</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 <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.) <b>4201</b>	
20c. TIME OF INJURY Hour _____ 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 _____
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21. I attended the deceased from **June 11, 1959** to **June 16, 1959** and last saw him alive on **June 16, 1959**  
Death occurred at **10:15 A.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John H. Flatz, M.D. John H. Flatz</b>	22b. ADDRESS <b>Carrollton, Mo.</b>	22c. DATE SIGNED <b>6-17-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/18/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Machpelan Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Lexington Mo.</b>
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24. FUNERAL DIRECTOR <b>Standley &amp; Gibson, Carrollton, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>6-18-59</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Herbert C. Reed</b>
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All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

56

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 *Ben W Gibson* .....

Licensed Embalmer No. *2961* .....  
P. O. Address *Carrollton, Va* .....

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.