

# R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024482

FILED VS. JUL 31 1959 71

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 41

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>IOWA</b> b. COUNTY <b>GUTHRIE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>EXCELSIOR SPRINGS</b>	Length of stay in 1b <b>7 DAYS</b>	c. CITY OR TOWN <b>JAMACIA</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>McCLEARY-THORNTON MURDER</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>RR.</b>

3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>WILLIAM</b> Last <b>CARVER</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>23</b> Year <b>1959</b>			
5. SEX <b>MALE</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>6-23-1929</b>	9. AGE (last birthday) <b>30</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during the most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	11. BIRTHPLACE (City and state or country) <b>BAYARD IOWA</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>CALVIN CARVER</b>		13b. MOTHER'S MAIDEN NAME <b>MARY WHETSTONE</b>		14. NAME OF HUSBAND OR WIFE <b>MARY E. ERLEBEN</b>		
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>483-44-9767</b>	17. INFORMANT Address <b>Hospital records.</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>Chronic Myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>One day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Age</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) <b>Praxetic Malnutrition</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 a.m. p.m.	Month, Day, Year	
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 **7-18-59** to **7-22-59** and last saw him alive on **7-22-59**  
Death occurred at **7:45 AM 7-22-59** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Thomas A. Workman MD</b>		22b. ADDRESS <b>Excelsior Springs Mo</b>		22c. DATE SIGNED <b>7/23/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>7-22-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>VALEZ HILL</b>	23d. LOCATION (City, town, or county) (State) <b>PERRY IOWA</b>		
24. FUNERAL DIRECTOR <b>Pitchard Funeral Home, Inc. Excelsior Springs, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>7-26-59</b>	26. REGISTRAR'S SIGNATURE <b>Caroline Hutchings</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 7 1959



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lindell J. Jansman

Licensed Embalmer No. 4589  
P. O. Address Excelsior Springs,

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.