

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-024831

FILED VS JUL 27 1959

Registration District No. 128 Primary Registration District No. 2000 STATE FILE NUMBER Registrar's No. 706B

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MARSHFIELD MO</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE</u> Length of stay in lb <u>3 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>10MI NORTH</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>JAMES KENNETH TARR</u>			4. DATE OF DEATH Month Day Year <u>JUNE 26 1959</u>
5. SEX <u>MALE</u> COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 23 1959</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>JOHN TARR</u> 13b. MOTHER'S MAIDEN NAME <u>GEORGIA MORGAN</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>JOHN TARR MARSHFIELD MO</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>stasis of the pulmonary valve, intra ventricular septal defect, inter-ventricular septal defect, adhesions of the gall bladder</u>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>7545</u>	
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 <u>6-23-59</u> to <u>6-26-59</u> and last saw her/him alive on <u>6-26-59</u> Death occurred at <u>315 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>David D. Thompson M.D.</u>		22b. ADDRESS <u>1630 Jefferson Springfield Mo.</u>	
22c. DATE SIGNED <u>7-20-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
23b. DATE <u>6-26-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>TIMBER RIDGE</u>	
23d. LOCATION (City, town, or county) <u>WEBSTER CO MO</u>		23e. (State)	
24. FUNERAL DIRECTOR ADDRESS <u>BARBER-EDWARDS MARSHFIELD</u>		25. DATE RECD. BY LOCAL REG. <u>7-24-59</u>	
26. REGISTRAR'S SIGNATURE <u>Effie S. Meeter</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

with, self care, public service, 00, 57, c, 1, All diseases in Part I must be causally related.

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 *George Stotep* .....

Licensed Embalmer No. *3161* .....

P. O. Address *Mt. Zion, Ill.* .....

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.