

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-025644

STATE FILE NUMBER

FILED JUL 16 1959

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 140

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JASPER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CARTHAGE		c. CITY OR TOWN SCOTLAND COMMUNITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MCCUNE-BROOKS HOSP. DOA		Length of stay in 1b 049⁰	
3. NAME OF DECEASED (Type or print) First OPAL Middle MARIE Last CARTER		4. DATE OF DEATH Month JULY Day 5 Year 1959	
5. SEX FEMALE	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 AUG. 17, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (City and state or country) BETHPAGE, MO.
13a. FATHER'S NAME A. M. BOWERS		13b. MOTHER'S MAIDEN NAME JANE SELF	14. NAME OF HUSBAND OR WIFE WALTER RAY CARTER
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. ----	17. INFORMANT Address W. RAY CARTER, RT 4, CARTHAGE, 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) Carcinomatous, Generalized Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Primary Carcinoma of Breast DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 170X			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Yrs. 4 Yrs.
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.			
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 5-3-59 to 7-5-59 and last saw ^{her} alive on 6-29-59 Death occurred at 4:18 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS	22c. DATE SIGNED 7-6-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7-6-59	23c. NAME OF CEMETERY OR CREMATORY FOREST PARK	23d. LOCATION (City, town, or county) (State) JOPLIN, MISSOURI
24. FUNERAL DIRECTOR STEVE PARKER MORTUARY, JOPLIN, MO.		25. DATE RECD. BY LOCAL REG. 7-6-59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *F. M. Jones*

Licensed Embalmer No. *3319*.....

P. O. Address *Joplin 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.