

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-026042

STATE FILE NUMBER

FILED JUL 16 1959 Registration District No. 243 Primary Registration District No. 4364 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <i>New tan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Arkansas</i> b. COUNTY <i>Benton</i>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Stella, Missouri</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Sulphur Springs</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Stella Hospital</i>		Length of stay in lb <i>10 days</i>		d. STREET ADDRESS <i>8030 #</i>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Cleveland</i> Last <i>Carey</i>				4. DATE OF DEATH Month <i>4</i> Day <i>25</i> Year <i>1959</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 22, 1885</i>		9. AGE (In years last birthday) <i>73</i>	IF UNDER 1 YEAR Months <i></i> Days <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (City and state or country) <i>Gravette, Arkansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13a. FATHER'S NAME <i>Cyrus Carey</i>			13b. MOTHER'S MAIDEN NAME <i>Cara Cantrell</i>			14. NAME OF HUSBAND OR WIFE <i>Minnie Carey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Minnie Carey, Sulphur Springs, Ark.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac decompensation</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Respiratory collapse due to</i>									
DUE TO (c) <i>pulmonary neoplasm</i>							<i>1 year</i>		
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.)						
20c. TIME OF INJURY Hour <i></i> Month, Day, Year <i></i> a.m. <i></i> p.m. <i></i>									
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. Attended the deceased from <i>3-1-59</i> to <i>4-25-59</i> and last saw <sup>her</sup> <sub>him</sub> alive on <i>4-25-59</i> Death occurred at <i>4:58</i> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>S.D. Fountain S.D.</i>				22b. ADDRESS <i>Moel Moel</i>				22c. DATE SIGNED <i>5-1-59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-27-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i>			23d. LOCATION (City, town, or county) (State) <i>Gravette, Arkansas</i>			
24. FUNERAL DIRECTOR <i>J.P. Lyath, Siloam Spgs, Ark</i>				25. DATE RECD. BY LOCAL REG. <i>7-6-59</i>		26. REGISTRAR'S SIGNATURE <i>Mildred Moberly</i>			

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

MEDICAL CERTIFICATION

Jurisdiction File Number 138-123  
Date Filed JUL 13 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 me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *J.P. Quattrone* .....  
Licensed Embalmer No. 1145

P. O. Address *Silver Spring, Md.*

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.