

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028889

FILED VS AUG 17 1959

Registration District No. 441 Primary Registration District No. 3025 Registrar's No. 94

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Norfolk</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Norfolk</u>					
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in 1b <u>3 yrs</u>		c. CITY OR TOWN <u>West Plains</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1125 St Lewis</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1125 St Lewis</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Sarah</u> Last <u>Carr</u>				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>59</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3/3/1899</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>5</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (City and state or country) <u>Brandenburg Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>W. H. Hunter</u>			13b. MOTHER'S MAIDEN NAME <u>Michael Callahan</u>			14. NAME OF HUSBAND OR WIFE <u>H. W. Hunter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>H. W. Hunter</u> Address <u>West Plains 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>Cerebral Hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerosis</u>					years <u>years</u>		
		DUE TO (c) <u>Diabetes & Hypertension</u>					years <u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 <u></u> Month, Day, Year <u></u>									
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 <u>3-19-56</u> to <u>7-10-59</u> and last saw her <u>alive</u> on <u>7-10-59</u> Death occurred at <u>4:20 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>J. S. [Signature]</u> (Degree or title)				22b. ADDRESS <u>West Plains Mo</u>			22c. DATE SIGNED <u>8/4/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>7-20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lone Star</u>			23d. LOCATION (city, town, or county) (State) <u>Missouri</u>			
24. FUNERAL DIRECTOR <u>Robertson West Plains Mo</u> ADDRESS <u></u>				25. DATE RECD. BY LOCAL REG. <u>8-13-59</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *D. J. Roberts*

Licensed Embalmer No. 343

P. O. Address West Hill

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.