URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–035755

STATE FILE NUMBER

FILED VS NOV 16 1959

Registration District No. 118 Primary Registration District No. 5440 Registrar's No. 37

AMENDED

1. PLACE OF DEATH
a. COUNTY Gasconade
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clay Twp. | Length of stay in 1b: 50 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Farm Home | Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri COUNTY Gasconade
c. CITY OR TOWN Bland | Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Rural Route | Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First CHARLIE Middle W. Last CARROLL

4. DATE OF DEATH: Month Nov. Day 9 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-22-1882

9. AGE (last birthday): 77

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HR: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (City and state or country): Osage County, Mo.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Daniel Carroll

13b. MOTHER'S MAIDEN NAME: Louisa Ellis

14. NAME OF HUSBAND OR WIFE: none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT Address: Mrs. Annie Carroll Owensville, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Left Hemiplegia	8 dys
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Hypertension	3 yrs
DUE TO (c)	Arteriosclerosis	3 yrs

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 11-1-59 to 11-9-59 and last saw him alive on 11-7-59

Death occurred at 6:30 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Paul A Brenner, M.D.

22b. ADDRESS: Owensville, Mo.

22c. DATE SIGNED: 11-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Nov. 11 1959

23c. NAME OF CEMETERY OR CREMATORY: New Bethel Cem.

23d. LOCATION (City, town, or county) (State): near Bland, Mo.

24. FUNERAL DIRECTOR ADDRESS: Gottenstroeter Funeral Home OWENSVILLE

25. DATE RECD. BY LOCAL REG.: November 10, 1959

26. REGISTRAR'S SIGNATURE: Mrs. Marvine Zappanya

Milford H Winter (Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by Me, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Milford H H We

Licensed Embalmer No. 383

P.O. Address OWENSV

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.