

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037304

FILED VS NOV 6 1959 314

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 571

ENDED

1. PLACE OF DEATH a. COUNTY St. Clair				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Clair			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Osceola		Length of stay in 1b Life		c. CITY OR TOWN Osceola		Inside Limits Y <input checked="" type="checkbox"/> N <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle M. Last Carrell				4. DATE OF DEATH Month Oct ; Day 17 , Year 1959			
5. SEX Male	6. COLOR OR RACE Colored	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/14/94	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Osceola Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Albert Carrell			13b. MOTHER'S MAIDEN NAME Elizabeth Cox		14. NAME OF HUSBAND OR WIFE Hannah E. Carrell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW#1			16. SOCIAL SECURITY NO. 499-09-1353	17. INFORMANT Hannah E. Carrell, Osceola Mo			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis						INTERVAL BETWEEN ONSET AND DEATH 2 wks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year					
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 1 July 54 to 17 Oct 59 and last saw ^{her} him live on 17 Oct 59 Death occurred at 10: A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE [Signature] (Degree or title) MD				22b. ADDRESS Osceola Missouri		22c. DATE SIGNED 10/19/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/20/59	23c. NAME OF CEMETERY OR CREMATORY Kate Warren		23d. LOCATION (City, town, or county) (State) Osceola Missouri		
24. FUNERAL DIRECTOR Goodrich Funeral Home, Osceola Mo			25. DATE RECD. BY LOCAL REG. 10 22 - 59		26. REGISTRARS SIGNATURE Ruth Seavers		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1959 NOV 6 SA

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 J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola

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.