

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 3 1960 47

-60-000547  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 5168 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> COUNTY <b>Montgomery</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kingdom City</b>		Length of stay in 1b <b>21 Hours</b>	c. CITY OR TOWN <b>Litchfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rainbow Motel</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>403 N. Chestnut</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>John</b> Last <b>Carter</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>30</b> Year <b>1960</b>	
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/5/1905</b>	9. AGE (last birthday) <b>54</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Litchfield, Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William Carter</b>	13b. MOTHER'S MAIDEN NAME <b>Lillian Hennesey</b>	14. NAME OF HUSBAND OR WIFE <b>D.K.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>332-20-8040</b>	17. INFORMANT <b>Mrs. William Carter, Litchfield, Ill.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound in right temple area</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Self inflicted</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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Same as in 18a above</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <b>about 8a Jan, 30, 60</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Rainbow Motel</b>	20f. CITY, TOWN, OR LOCATION <b>Kingdom City</b>	COUNTY <b>Callaway</b>	STATE <b>Mo</b>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **About 8 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Denzil C. Browning coroner</b>	(Degree or title)	22b. ADDRESS <b>Fulton, Mo.</b>	22c. DATE SIGNED <b>Jan 30-60</b>
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23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE <b>Feb 2, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Litchfield Illinois</b>
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24. FUNERAL DIRECTOR <b>Wallace Funeral Home, Fulton, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Jan 30-1960</b>	26. REGISTRAR'S SIGNATURE <b>Maretta Lawrence</b>
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Denzil C. Brown

Licensed Embalmer No. 272

P. O. Address Fulton

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