

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960

=60-001019

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 112

STATE FILE NUMBER

4321

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>11 Days</u>	c. CITY OR TOWN <u>Aurora</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>St. John's</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>20 W Coffield St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>John Craig Carter</u>			4. DATE OF DEATH Month Day Year <u>January 26 1960</u>	
--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/13/60</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months <u>13</u> Days <u>13</u> Hours <u>0</u> Min. <u>0</u>
-----------------------	----------------------------------	---	------------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Aurora, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	--	--	---

13a. FATHER'S NAME <u>John Carter</u>	13b. MOTHER'S MAIDEN NAME <u>Virginia Gambell</u>	14. NAME OF HUSBAND OR WIFE <u>- - - - -</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>John Carter; Aurora, Mo</u>	Address <u>- - - - -</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>Congenital trachea esophageal fistula, part of status</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Proteinuria, night my</u>	
	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 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 a.m. 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 <u>JAN 15-60</u> to <u>JAN 26-60</u> and last saw her/him alive on <u>JAN 26-60</u> Death occurred at <u>5:05 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE <u>John W. Dick, MD</u> (Degree title)	22b. ADDRESS <u>Springfield, Mo</u>	22c. DATE SIGNED <u>1-28-60</u>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/28/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u>	23d. LOCATION (City, town, or county) <u>Aurora, Mo.</u>	(State)
--	-----------------------------	--	---	---------

24. FUNERAL DIRECTOR <u>Arnold's Funeral Home; Aurora, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-29-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</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 Irvin R. Arnold

Licensed Embalmer No. 4929

P. O. Address Avoca, N.

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