URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-010729

STATE FILE NUMBER

NDED

Registration District No. 141 Primary Registration District No. 3a 25 Registrar's No. 54

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN West Plains, — Length of stay in 1b: 6 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Howell
c. CITY OR TOWN West Plains — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 105 E. Olden — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First James Middle Henry Last Carlile
4. DATE OF DEATH: Month March Day 29 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 3-12-73
9. AGE (last birthday): 87
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): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Salem, Arkansas
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Harve Carlile
13b. MOTHER'S MAIDEN NAME: Sarah (Unknown)
14. NAME OF HUSBAND OR WIFE: Margaret Carlile
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Alta Johnson, West Plains, Mo. Address

MEDICAL CERTIFICATION

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: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
① Generalized Arteriosclerosis ② Senility
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 4-15-59 to 3-29-60 and last saw ~~him~~ him alive on 3-28-60
Death occurred at 1:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Doctor or title) Jack N. Wiles M.D.
22b. ADDRESS West Plains, Mo.
22c. DATE SIGNED 3-30-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4-1-1960
23c. NAME OF CEMETERY OR CREMATORY: Koshkonong, cemetery
23d. LOCATION (City, town, or county) (State): Koshkonong, Missouri
24. FUNERAL DIRECTOR: Leland Carter ADDRESS: West Plains, Mo.
25. DATE RECD. BY LOCAL REG.: 4-1-60
26. REGISTRAR'S SIGNATURE: Beatrice Cook

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4576

P. O. Address

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