

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011447

FILED VS MAR 16 1960 /57

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STATE FILE NUMBER  
60-011447

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

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b>		b. COUNTY <b>Jasper</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Carthage</b>		Length of stay in 1b <b>8 Days</b>		c. CITY OR TOWN <b>Carthage</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>McCune Brooks Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>1112 S. Main</b>	
				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Wilson</b>			Middle <b>Elrod</b>			Last <b>Elrod</b>			4. DATE OF DEATH Month <b>March</b>			Day <b>7</b>			Year <b>1960</b>		
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>3-17-1869</b>		9. AGE (last birthday) <b>90</b>		IF UNDER 1 YEAR Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Western Union Mgr.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Western Union</b>				11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.S.A.</b>					
13a. FATHER'S NAME <b>William Elrod</b>						13b. MOTHER'S MAIDEN NAME <b>Mary</b>						14. NAME OF HUSBAND OR WIFE <b>Faye B. Elrod</b>					
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>unknown</b>						17. INFORMANT Address <b>Mrs. Faye Elrod, Carthage, Mo.</b>					

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><b>Uremia</b></u>												INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												DUE TO (b) <u><b>Septicemic Cholemia</b></u>		DUE TO (c) <u><b>unknown</b></u>	

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 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 <b>Carthage, Mo.</b>				COUNTY		STATE	

21. I attended the deceased from **8-1-58** to **3-7-1960** and last saw <sup>her</sup>him alive on **3-6-60**  
Death occurred at **3:45 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>W. M. D.</i> (Degree or title)				22b. ADDRESS <b>Carthage, Mo.</b>				22c. DATE SIGNED <b>3-7-60</b>			
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-10-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Cemetery</b>				23d. LOCATION (City, town, or county) <b>Carthage, Mo.</b>					
24. FUNERAL DIRECTOR <b>Ulmer Funeral Home, Carthage, Mo.</b>				ADDRESS				25. DATE RECD. BY LOCAL REG. <b>3-8-60</b>		26. REGISTRAR'S SIGNATURE <i>W. M. D.</i>			

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 me  
or by Don B. Housh, <sup>Permit</sup> Student Embalmer No. 4

working under my personal supervision.

Student Don B. Housh  
Signature of Student Embalmer

Signed Edwin C. Brown

Licensed Embalmer No. 4955

P. O. Address Cartersville

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.