

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-019008**

**FILED VS MAY 31 1960**

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 606

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Greene</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b		c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>RFD #11</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Charlie</b> Middle <b>Weast</b> Last <b>Carr</b>				<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>24</b> , Year <b>1960</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>19 July 1868</b>	<b>9. AGE</b> (last birthday) <b>91</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>		
<b>13a. FATHER'S NAME</b> <b>Henry H. Carr</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Cynthia Stubblefield</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Deceased</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> Address <b>Henry Carr (Son) Rt. 11 Springfield, Mo.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular. Pulm Disease</b> DUE TO (b) <b>Ageing process.</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH		
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.		Month, Day, Year						
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY	STATE	
<b>21. I attended the deceased from</b> <u>6-11-50</u> to <u>5/24/60</u> and last saw <sup>her</sup> him alive on <u>5/24/60</u> Death occurred at <u>4:20</u> P. m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <i>John Weast Jr. M.D.</i>				<b>22b. ADDRESS</b> <b>Landers Building                  Springfield, Missouri</b>		<b>22c. DATE SIGNED</b> <b>5-25-60</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>5/27/60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Greenlawn</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Springfield, Missouri</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Klingner Mortuary</b>			ADDRESS <b>Springfield, Mo.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>5-26-60</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Effie E. Melton</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

jhc

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

Signed \_\_\_\_\_

Licensed Embalmer No. 4071

P. O. Address \_\_\_\_\_

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.