

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-036202

FILED VS SEP 1 2 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 876 H

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>WRIGHT</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in lb <b>1-WEEK</b>		c. CITY OR TOWN <b>MTN. GROVE</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>SPRINGFIELD BAPTIST HOSP.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>NORTH STAR. RT.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES EDWARD CARDER</b>				4. DATE OF DEATH Month Day Year <b>AUG. 18 - 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>OCT. 13 1903</b>	9. AGE (last birthday) <b>56</b>		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) <b>FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CARPENTER</b>		11. BIRTHPLACE (City, and state or country) <b>WRIGHT COUNTY, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>JOHN CARDER</b>			13b. MOTHER'S MAIDEN NAME <b>MARY CHRISTINE HENSON</b>			14. NAME OF HUSBAND OR WIFE <b>LILLIE MINGS</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.		17. INFORMANT Address <b>STAIR RT. MTN. GROVE</b> <b>LILLIE CARDER</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) <b>Cerebral Vascular Accident</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Intra Cerebral Neoplasm - Suspected 2 mo.</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			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <b>8/8/60</b> to <b>8/18/60</b> and last saw her/him alive on <b>8/18/60</b> Death occurred at <b>12:40 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>J. E. Barber M.D.</b>				22b. ADDRESS <b>Springfield Mo</b>				22c. DATE SIGNED <b>9/1/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>8-18-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNTAIN</b>			23d. LOCATION (City, town, or county) <b>GREEN MTN. MO.</b>				
24. FUNERAL DIRECTOR <b>BARBER F. HOME</b>				ADDRESS <b>MTN. GROVE</b>		25. DATE RECD. BY LOCAL REG. <b>9-6-60</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Meeter</b>	

(Licensed Embalmer's Statement on Reverse Side)

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 *RWT Bar*

Licensed Embalmer No. 38

P. O. Address 710m

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