MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-034536

FILED VS OCT 3 1960

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 232 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY: Henry
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Clinton
Length of stay in 1b: 10 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Forrest Rest Home
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Henry
c. CITY OR TOWN: Urich
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: William Middle: Lovel Last: Carpenter

4. DATE OF DEATH: Month, Day, Year: Sept;23,1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]

8. DATE OF BIRTH: 6/25/77

9. AGE (last birthday): 83

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): Farming

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): St. Clair Co;Mo.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: John Carpenter

13b. MOTHER'S MAIDEN NAME: Annie Allen

14. NAME OF HUSBAND OR WIFE: May Carpenter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT Address: May Carpenter, Urich Missouri

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pneumonia (Hypostatic)	1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Diabetes	10 days
DUE TO (c)	Parkinson Disease	2½ years

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. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 4-5-58, to 9-23-60 and last saw her/him alive on 9-23-60

Death occurred at 5:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Lane A. McFadden M.D.

22b. ADDRESS: 114 N. Jefferson Clinton Mo.

22c. DATE SIGNED: 9-27-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 9/27/60

23c. NAME OF CEMETERY OR CREMATORY: Kings Prairie

23d. LOCATION (City, town, or county) (State): Osceola Missouri

24. FUNERAL DIRECTOR ADDRESS: Goodrich Funeral Home, Osceola Mo.

25. DATE RECD. BY LOCAL REG.: Sept. 27-1960

26. REGISTRAR'S SIGNATURE: Mildred Bigom

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 F B [illegible]

Signature of Student Embalmer

Licensed Embalmer No. 3038

P. O. Address Osceola

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.