

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-037360

FILED VS OCT 26 1960

Registration District No. 13 Primary Registration District No. 3003 Registrar's No. 7193

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY BARRY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MONETT		a. STATE MO.		b. COUNTY BARRY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST VINCENT HOSPITAL		Length of stay in 1b 5 days		c. CITY OR TOWN SELIGMAN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First MARY		Middle ETTA		Last CARLTON		Month 10 Day 12 Year 60	
5. SEX F	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/22/76	9. AGE (last birthday) 84	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Rockford, Alabama		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John Magouyrk			13b. MOTHER'S MAIDEN NAME Annie Heron		14. NAME OF HUSBAND OR WIFE J.S. Carlton		
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. none		17. INFORMANT J.S. Carlton, Seligman, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - left brain play in						INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive cardio-vascular renal disease						DUE TO (c) 15 yrs	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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		COUNTY STATE	
21. I attended the deceased from <u>1955</u> to <u>10/17/60</u> and last saw her alive on <u>10/12/60</u> Death occurred at <u>8:25 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Dr. Robert P. Dooley M.D.				22b. ADDRESS Wynne H. Wood		22c. DATE SIGNED 10/14/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/14/60		23c. NAME OF CEMETERY OR CREMATORY Wynne Wood, Oklahoma		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR Wm. Williamson, Cassville, Mo.				25. DATE RECD. BY LOCAL REG. 10-14-60		26. REGISTRAR'S SIGNATURE Mrs. P.H. Cook	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 1 1960

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 Daryl E. Williams

Licensed Embalmer No. 4883

P. O. Address Cassville

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.