

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

-60-037764

FILED VS OCT 17 1960

STATE FILE NUMBER

Registration District No. 65 Primary Registration District No. _____ Registrar's No. 30

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Chariton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Chariton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.F.D 2</u>		Length of stay in 1b <u>47 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>R.F.D 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Miner</u> Middle <u>Cecil</u> Last <u>Stanley</u>			4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>1960</u>				
5. SEX (<u>M</u>)	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1890</u>		9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (City and state or country) <u>Chariton Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	

13a. FATHER'S NAME <u>William</u>		13b. MOTHER'S MAIDEN NAME <u>America Washburn</u>		14. NAME OF HUSBAND OR WIFE <u>Beriah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Beriah Stanley Brookfield, MO</u> Address	

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>Coronary thrombosis with myocardial infarction.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>4201</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? 2. 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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <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 Death occurred at <u>June 1949</u> <u>4:15</u> <u>A.M.</u>		and last saw ^{her} him alive on <u>Oct. 10, 1960</u> <u>Oct. 10, 1960</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>John Otis Carr D.O.</u>		22b. ADDRESS <u>124 W. Ritchie, Marceline, MO.</u>	
		22c. DATE SIGNED <u>10-11-60</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE <u>10-12-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rothville, Mo</u>		23d. LOCATION (City, town, or county) (State) <u>Rothville, Mo.</u>	
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24. FUNERAL DIRECTOR <u>James M. Laughlin Marceline, Mo</u>		25. DATE RECD. BY LOCAL RES. <u>Oct 14 - 1960</u>		26. REGISTRAR'S SIGNATURE <u>Howell Smith</u>	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

OCT 27 1960

OCT 18 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 me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Edward L. Wade*

Licensed Embalmer No. *4172*

P. O. Address *Brown*

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.