

I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-042719
STATE FILE NUMBER

FILED VS. DEC 1 2 1960 184

Registration District No. 184 Primary Registration District No. 5687 Registrar's No. 143

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Linn</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield Twp.</u> Length of stay in lb <u>63 years</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.J.D.#2</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R.J.D.#2</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Ann Carey</u>			4. DATE OF DEATH Month Day Year <u>November 30, 1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/1873</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>26</u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>in own home</u>		11. BIRTHPLACE (City and state or country) <u>Brookfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>James Carroll</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Orr</u>		14. NAME OF HUSBAND OR WIFE <u>Cornelius Carey (deceased)</u> (Con) <u>Carey</u>		Address <u>Brookfield, Mo.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Bernadine Carey, Brookfield, Mo.</u>		Address <u>Brookfield, Mo.</u>	
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>Cerebral vascular accident</u> DUE TO (b) <u>Generalized arteriosclerosis vasculature 5 yrs</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>A.O.A.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive Heart Failure</u>					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 checked="" type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1011/59</u>		20f. CITY, TOWN, OR LOCATION <u>1011/59</u>		COUNTY <u> </u> STATE <u> </u>			
21. I attended the deceased from <u>10/1/59</u> to <u>10/15/60</u> and last saw her alive on <u>10/15/60</u> . Death occurred at <u>11-30-60</u> <u>7:18</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>R. W. Bohart M.D.</u>			22b. ADDRESS <u>Brookfield Mo</u>		22c. DATE SIGNED <u>12/7/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 3, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael Cemetery</u>		23d. LOCATION (City, town, or county) <u>Brookfield, Missouri</u>		
24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-3-60</u>		26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>			

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 Gerald F. Wald

Licensed Embalmer No. 417

P. O. Address Brown

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