

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-008570

STATE FILE NUMBER

AMENDED

Registration District No. 142 Primary Registration District No. 56876 Registrar's No. 9

FILED MAR 27 1961

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Caldsberry</u>		Length of stay in 1b	c. CITY OR TOWN <u>Summersville</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>St. Francis Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Saura</u> Middle <u>Eddythe</u> Last <u>Correll</u>			4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>6/11/06</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months Days Hours Min.
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	11. BIRTHPLACE (City and state or country) <u>Arroll, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>Edward A. Joll</u>		13b. MOTHER'S MAIDEN NAME <u>Adeline Woolsey</u>		14. NAME OF HUSBAND OR WIFE <u>Floyde Eugene Correll</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. <u>yes</u>	17. INFORMANT Address <u>Floyde E. Correll Rt. 1 Smosville, 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>Myocardial Infarction</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Essential hypertension; Cerebral hemorrhage</u>		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	
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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
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21. I attended the deceased from Feb 24 1961 to Mar 15, 1961 and last saw her/him alive on Mar 15, 1961
Death occurred at March 15 - 1961 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>M. C. Walton M.D.</u>	22b. ADDRESS <u>White View Mo</u>	22c. DATE SIGNED <u>3-17-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/18/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakside Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mtn. View, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Duncan Funeral Home Mtn. View, Mo.</u>	25. DATE REC'D. BY LOCAL REG. <u>3-20-61</u>	26. REGISTRAR'S SIGNATURE <u>Saura Mitchell</u>
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

APR 4 1961

APR 28 1961

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 Charles D. Cartain

Licensed Embalmer No. 5187

P. O. Address Monte Vista

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.