

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020033

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 96

FILED JUN 15 1961

1. PLACE OF DEATH a. COUNTY <u>SALINE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>SALINE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARSHALL</u>		Length of stay in 1b <u>5 hrs</u>	c. CITY OR TOWN <u>NELSON</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>Fitzgibbon Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6-M-SW NELSON</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>CLIFFORD</u> Last <u>MOUNTS</u>			4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1961</u>		
5. SEX <u>MALE</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>2-22-1898</u>	9. AGE (last birthday) <u>63</u>	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) <u>SUPERINTENDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE FACTORY</u>	11. BIRTHPLACE (City and state or country) <u>SALINE Co., Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>THOMAS E. MOUNTS</u>		13b. MOTHER'S MAIDEN NAME <u>BESSIE BENNETT MOUNTS</u>		14. NAME OF HUSBAND OR WIFE <u>DAISY MOUNTS</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>X</u>	17. INFORMANT <u>Mrs. Daisy Mounts - Nelson, 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>Posterior Myocardial infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					
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 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>March 1960</u> to <u>June 1961</u> and last saw ^{her} him alive on <u>June 3 1961</u> Death occurred at <u>2 5/8 pm</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>W. A. Reser</u>			22b. ADDRESS <u>MARSHALL, Missouri</u>		22c. DATE SIGNED <u>6-5-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-5-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET CEMETERY</u>	23d. LOCATION (City, town, or county) <u>MARSHALL</u>	23e. (State) - <u>Missouri</u>	
24. FUNERAL DIRECTOR <u>JACK W. RESER</u>		ADDRESS <u>MARSHALL</u>	25. DATE RECD. BY LOCAL REG. <u>6-5-61</u>	26. REGISTRAR'S SIGNATURE <u>W. A. Reser</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

JUN 27 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 Jack W. Reese

Licensed Embalmer No. 4643
P. O. Address Marshall, W. Va.

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.