

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039955

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 379 Primary Registration District No. 4543 Registrar's No. 19

FILED NOV 13 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>WEBSTER</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SEYMOUR</u>		Length of stay in 1b	c. CITY OR TOWN <u>SEYMOUR</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION		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) First Middle Last <u>SAMUEL ROBERT CARRICK</u>			4. DATE OF DEATH Month Day Year <u>11-8-61</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>SEPT 23 1877</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>WEBSTER Co. Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <u>JOE CARRICK</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA SIVENS</u>		14. NAME OF HUSBAND OR WIFE <u>ELSIE</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>No</u>	17. INFORMANT Address <u>MRS. MARTHA SPRIGGS SEYMOUR, 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>Sepsis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>
DUE TO (b) <u>Decubital Cellulitis caused by prolonged Recumbency</u>					
DUE TO (c) <u>Arteriosclerosis</u>					
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 checked="" 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>11-10-59</u> to <u>11-8-1961</u> and last saw him/her alive on <u>11/1/1961</u> . Death occurred at <u>1:25 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>J.R. Hill A.O.</u>			22b. ADDRESS <u>Seymour</u>		22c. DATE SIGNED <u>11/10/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-11-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SEYMOUR MASONIC</u>	23d. LOCATION (City, town, or county) <u>WEBSTER Co. Mo.</u>		
24. FUNERAL DIRECTOR <u>Robert Bengtson Seymour, Mo.</u>		ADDRESS <u>Seymour, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-11-1961</u>	26. REGISTRAR'S SIGNATURE <u>Gilbert Jones</u>	

OCT 18 1962

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 Max F Miller

Licensed Embalmer No. 4720

P. O. Address Manassas Mo

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.