

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010170

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 58 Primary Registration District No. 4091 Registrar's No. 5

STATE FILE NUMBER

FILED MAR 30 1962

1. PLACE OF DEATH a. COUNTY <u>Carter</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fremont</u>		c. CITY OR TOWN <u>Sedalia</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NORRIS Garage-Hwy 60</u>		d. STREET ADDRESS (If outside, give location) <u>2528 N. Woodlawn Dr</u>	
3. NAME OF DECEASED (Type or print) First <u>Royal</u> Middle <u>Witter</u> Last <u>Cary</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</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>11/2/1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATE REPRESENTATIVE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MUTUAL INSURANCE</u>	
13a. FATHER'S NAME <u>MERTON E. CARY</u>		13b. MOTHER'S MAIDEN NAME <u>OLIVE WITTER</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>312-03-0198</u>	
17. INFORMANT <u>C. E. Sheldon</u>		14. NAME OF HUSBAND OR WIFE <u>IRMA PAULSON CARY</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>Frontal Skull Fracture</u> DUE TO (b) <u>Auto Accident</u> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</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 checked="" 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.) <u>Impact of Car - Caused Compound Fracture</u>	
20c. TIME OF INJURY Hour <u>10:00</u> a.m. <u>pm</u> Month, Day, Year <u>3-16-62</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 60</u>		
20e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Fremont</u>		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>10:00A</u> on the date stated above, and to the best of my knowledge, from the causes stated.		COUNTY <u>Carter</u> STATE <u>Mo</u>	
22a. SIGNATURE (Degree or title) <u>Coleman McHadden</u>		22b. ADDRESS <u>Van Buren, Mo</u>	
22c. DATE SIGNED <u>3-16-62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>3/20/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>MASON CITY, IOWA</u>		24. FUNERAL DIRECTOR <u>McHadden</u>	
25. DATE RECD. BY LOCAL REG. <u>Mar. 23-62</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Octa Henson</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DATE AMENDED

INSTEAD OF

USE BLACK INK  
OR  
TYPEWRITER RIBBONVS 300  
Rev. 4/5961802808

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110181291-3131-0

NS MAR 30 1962

APR 24 1962

APR 4 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 Allen C. McGee

Licensed Embalmer No. 4543

P. O. Address Van Buren, 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.