

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000226

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 80

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 4 1963		1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>24 Days</u>		c. CITY OR TOWN <u>Lilbourn</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>UNIVERSITY OF MO. Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William CARTER</u>			4. DATE OF DEATH Month Day Year <u>2 / 1 / 63</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>5/24/97</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.I.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George CARTER</u>		13b. MOTHER'S MAIDEN NAME <u>NORTHANA GARRISON</u>		14. NAME OF HUSBAND OR WIFE <u>MRS Mac CARTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT Address <u>UNIVERSITY OF MO. Medical Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Post operative atelectasis</u> DUE TO (c) <u>Carcinoma of Stomach</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 days</u> <u>1 year</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 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>1-7-63</u> to <u>Death</u> and last saw him alive on <u>2-1-63</u> Death occurred at <u>5:15</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>UMMC Columbia Mo</u>		22c. DATE SIGNED <u>2-1-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>FEB 1, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stangfield-Clarkton Mo</u>	
24. FUNERAL DIRECTOR <u>PARKER FUNERAL SERVICE, Columbia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 1 1963</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF: DATE AMENDED DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

ITEM NO. SHOULD READ

3	
4	<u>0</u>
5	<u>1</u>
6	
7	<u>1</u>
8	<u>1</u>
9	<u>151X</u>
10	
11	
12	<u>2-0</u>
13	<u>3-0</u>

FEB 13 1963

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 J. W. Phillips
Licensed Embalmer No. 4897

P. O. Address Columbia, 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.