

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-014569

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 85

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 1 1963

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>SCOTT</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>NEW MADRID</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>SIKESTON</b>                            |  | Length of stay in 1b<br><b>4 days</b>   | c. CITY OR TOWN <b>CANALOU</b>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>MO. DELTA COMMUNITY HOSP.</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |  |  |                                    |  |  |
|---|--|--|------------------------------------|--|--|
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ANDREW CARROLL</b> |  |  | 4. DATE OF DEATH<br><b>3-26-63</b> |  |  |
|---|--|--|------------------------------------|--|--|

|                       |                                  |   |  |                                     |   |
|-----------------------|----------------------------------|---|--|-------------------------------------|---|
| 5. SEX<br><b>MALE</b> | 6. COLOR OR RACE<br><b>WHITE</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 4, 1903</b> | 9. AGE (last birthday)<br><b>59</b> | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>22</b> Hours <b></b> Min. <b></b> |
|-----------------------|----------------------------------|---|--|-------------------------------------|---|

|   |   |  |   |
|---|---|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).<br><b>Farmer</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b> | 11. BIRTHPLACE (City and state or country)<br><b>Matthews, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
|---|---|--|---|

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|---|---|--|
| 13a. FATHER'S NAME<br><b>John Carroll</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Henretta Powell</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Hattie Carroll</b> |
|---|---|--|

|  |                                      |  |
|--|--------------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates)<br><b>no</b> | 16. SOCIAL SECURITY NO.<br><b>no</b> | 17. INFORMANT Address<br><b>Hattie Carroll, Canalou, Mo.</b> |
|--|--------------------------------------|--|

|  |  |
|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b><br><b>CER. VASC. ACCID. RT. HEMIPLERIA 4d.</b><br><b>CER. ART SCLEROSIS</b><br>DUE TO (b)<br>DUE TO (c) | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2</b> |
|--|--|

|  |  |
|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition (given in PART I. (a))<br><b>Ess. HYPERTENSION</b> | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|--|--|

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|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <b></b> a.m. <b></b> p.m. <b></b> | Month, Day, Year <b>1961</b> |
|---|------------------------------|

|  |   |   |
|--|---|---|
| 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.)<br><b>1961</b> | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
|--|---|---|

21. I attended the deceased from **1961** to **3-26-63** and last saw him  alive on **3-26-63**  
Death occurred at **5:55 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                   |                                 |
|--|-----------------------------------|---------------------------------|
| 22a. SIGNATURE <b>Carl C. Bopp, M.D.</b> (Degree or title) | 22b. ADDRESS <b>SIKESTON, MO.</b> | 22c. DATE SIGNED <b>3.26.63</b> |
|--|-----------------------------------|---------------------------------|

|  |                                    |   |   |
|--|------------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>March 28, 1963</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dogwood Cemetery East Prairie, Mo.</b> | 23d. LOCATION (City, town, or county) (State) |
|--|------------------------------------|---|---|

|   |   |   |
|---|---|---|
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Albritton Funeral Home Sikeston, Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>March 28, 1963</b> | 26. REGISTRAR'S SIGNATURE<br><b>Janette Waldman</b> |
|---|---|---|

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

|                 |             |
|-----------------|-------------|
| DATE AMENDED    | AMENDED     |
| 1007            |             |
| 20720           |             |
| 3               |             |
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| 9331X           |             |
| 10              |             |
| 11              |             |
| 121-0           |             |
| 132-0           |             |
| ITEM NO.        | SHOULD READ |
| BY AFFIDAVIT OF | DOCUMENT    |

APR 1 1963

Permit issued March 27-1962

**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 Raymond L. Duppe

Licensed Embalmer No. 4798

P. O. Address Bernie, 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.