

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-046661

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 137

Primary Registration District No. 3023

Registrar's No. 384

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 26 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Henry</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Henry</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u>		Length of stay in 1b <u>4 Yr.s</u>	c. CITY OR TOWN <u>Clinton</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 <u>901 N 2nd St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>901 N 2nd St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louella</u> Middle <u>Ross</u> Last <u>Carrington</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1962</u>		
5. SEX <u>Female</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>9-29-1882</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Blairstown Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>Charles P Swaggart</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Kinelman</u>		14. NAME OF HUSBAND OR WIFE <u>Robert W Carrington</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>494-16-3871</u>	17. INFORMANT Address <u>21 N Main</u> <u>Robert Carrington Clinton 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>Lobar Pneumonia</u> DUE TO (b) <u>Inanition & debility</u> DUE TO (c) <u>CVA</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u> <u>5 years</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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>	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>10-15-61</u> to <u>12-11-62</u> and last saw her ^{her} alive on <u>12-10-62</u> Death occurred at <u>1:35 A.M</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R J Powell Do.</u> (Degree or title)			22b. ADDRESS <u>Clinton Mo</u>		22c. DATE SIGNED <u>12/19/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-13-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blairstown Cem</u>		23d. LOCATION (City, town, or county) <u>Blairstown</u>	STATE <u>Mo</u>
24. FUNERAL DIRECTOR <u>Sickman & Dunning Clinton Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Dec 13 1962</u>	26. REGISTRAR'S SIGNATURE <u>Wildred Bigum</u>	

RECEIVED

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 Robert L. Dunning

Licensed Embalmer No. 4510

P. O. Address Clinch, 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.

Permit Board 12-13-52 W.B. Rip.