

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34707

State File No. _____

FILED OCT 24 1956

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 199

1. PLACE OF DEATH a. COUNTY <u>Lumpkin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Lumpkin</u>	
b. CITY (If outside corporate limits write RURAL and give township) OR TOWN <u>Chillicothe</u>		c. CITY OR TOWN <u>Chillicothe</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>5 yr</u>		e. STREET ADDRESS (If rural, give location) <u>505 Calhoun 05⁹²</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Minnie</u> b. (Middle) <u>Lee</u> c. (Last) <u>Carlyle</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10 14 56</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug 19-1878</u>		9. AGE (In years last birthday) <u>78</u>
10. USUAL OCCUPATION (Give kind of work and during most of working life, specify if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drugg</u>		11. BIRTH PLACE (City and State or Foreign Country) <u>Ky</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>					

13a. FATHER'S NAME <u>James H. Collins</u>		13b. MOTHER'S MAIDEN NAME <u>Sula Paterson</u>		14. NAME OF HUSBAND OR WIFE <u>Luther Pierce Carlyle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state way or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Collins Carlyle HICKMAN MILLS</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute coronary occluding</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>		?
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4201</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 10-14, 1956, to 10-14, 1956, that I last saw the deceased alive on 10-14, 1956, and that death occurred at Lice R. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dorothy F. Cole, M.D.</u>	23b. ADDRESS <u>Chillicothe Mo</u>	23c. DATE SIGNED <u>10-15-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-16-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Edgewood</u>	24d. LOCATION (City, town, or county) (State) <u>Chillicothe Mo</u>
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DATE REC'D BY LOCAL REG. <u>10/15/56</u>	REGISTRAR'S SIGNATURE <u>Frances B Nail</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Chechott Chillicothe Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *E. Beckwith*

Licensed Embalmer No. *322*

P. O. Address *Chillicothe*

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.