

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23835**

FILED AUG 6 1957

BIRTH NO. _____ REG. DIST. NO. **55** PRIMARY REG. DIST. NO. **3011** Registrar's No. **62**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Mo. b. COUNTY Carroll	
b. CITY (If outside corporate limits, write RURAL and give township) Carrollton		c. CITY OR TOWN Carrollton	c. LENGTH OF STAY (in this place) 20 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Wetzel Hospital		e. STREET ADDRESS (If rural, give location) 207 E. Fourth	
3. NAME OF DECEASED a. (First) THOMAS (Type or Print)		b. (Middle) R.	
c. (Last) PERSINGER		4. DATE OF DEATH (Month) (Day) (Year) July 27, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 5, 1880
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (City and State or Foreign Country) McFall, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Joseph Persinger		13b. MOTHER'S MAIDEN NAME Malinda Teel	
14. NAME OF HUSBAND OR WIFE Maude Persinger		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. T. R. Persinger, Carrollton, Mo	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Artery Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis? DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Aneurysm of Abd. Aorta.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201	
20. AUTOPSY? = YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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)	
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 2-6-54 , to 7-27 , 1957, that I last saw the deceased alive on 7-27 , 1957, and that death occurred at 8:30P. m. , from the causes and on the date stated above.			
23a. SIGNATURE William S. Everett		23b. ADDRESS Carrollton Mo	
23c. DATE SIGNED 7-29-57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/30/1957	
24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cem.		24d. LOCATION (City, town, or county) (State) Carrollton, Mo.	
DATE REC'D BY LOCAL REG. 7/30/57		REGISTRAR'S SIGNATURE Mrs. Lillian Calvert	
25. FUNERAL DIRECTOR'S SIGNATURE Standley & Gibson, Carrollton, Mo.		ADDRESS	

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 *Ben W. Gibson*

Licensed Embalmer No. 2961

P. O. Address Carrollton, 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.