

FILED SEP 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28171

STATE FILE NUMBER

Registration District No. 145 Primary Registration District No. 55 LL Registrar's No. 128

1. PLACE OF DEATH a. COUNTY <u>Iron</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Iron</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Courtois</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Courtois</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>Courtois</u>		Length of stay in lb <u>10 Yrs.</u>	d. STREET ADDRESS (If outside, give location) -----		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>Carl</u> Last <u>Carl</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1957</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>March 30, 1886</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <u>Belgrade, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Carl</u>			14. MOTHER'S MAIDEN NAME <u>Rebecca Corder</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>Unknown</u>	17. INFORMANT <u>Mrs. Claude Carl Courtois, 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>Medullary paralysis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>1 week</u> <u>33 1/2 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>					
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. _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE		
21. I attended the deceased from <u>April 1955</u> to <u>4 Sep 1957</u> and last saw her/him alive on <u>4 Sep 1957</u> Death occurred at <u>4:50 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R. A. Hendigate</u> (Degree or title) <u>D.O.</u>			22b. ADDRESS <u>Bismarck, Mo.</u>		22c. DATE SIGNED <u>9-5-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/8/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Indian Creek Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Washington County, Mo.</u>		
24. FUNERAL DIRECTOR <u>Bert L. Boyer</u>		ADDRESS <u>Leadwood, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 11 - 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Elizabeth Logan</u>	

(Licensed Embalmer's Statement on Reverse Side)

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *William E. Boyer*
.....

Licensed Embalmer No. *47*

P. O. Address *Leadwood*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.