

FILED NOV 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35092**

BIRTH NO. _____		REG. DIST. NO. <u>58</u>		PRIMARY REG. DIST. NO. <u>5212</u>		Registrar's No. <u>29</u>			
1. PLACE OF DEATH a. COUNTY <u>Carter</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u>				b. COUNTY <u>Carter</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>van Buren</u>		c. LENGTH OF STAY (in this place) <u>11 yrs</u>		c. CITY OR TOWN <u>Rural</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Own Home</u>				e. STREET ADDRESS (If rural, give location) <u>0180</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u>		b. (Middle) <u>Harris</u>		c. (Last) <u>Folsom</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 28 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>July 17 1880</u>			
9. AGE (In years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Common laborer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>July 7 Roseville Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME <u>Nathaniel Folsom</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Ritchie</u>		14. NAME OF HUSBAND OR WIFE <u>Maie Folsom</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>356-65-9855</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Maie Folsom Van Buren</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute circulatory failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Coronary Thrombosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
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) m.		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 <u>7-15</u> , 19 <u>49</u> , to <u>10-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-28</u> , 19 <u>57</u> , and that death occurred at <u>3:55 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Frank J. Recerski, M.D.</u>				23b. ADDRESS <u>Van Buren Mo</u>		23c. DATE SIGNED <u>10-29-57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct 31 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Prairie City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Prairie City Ill</u>			
DATE REC'D BY LOCAL REG. <u>Oct. 29-57</u>		REGISTRAR'S SIGNATURE <u>Mrs Oeta Henson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Seaton Perwith</u>		ADDRESS <u>Van Buren Mo</u>			

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

RECEIVED

OCT 31 1957

CARTER COUNTY
HEALTH CENTER

NOV 15 1957

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.....

Licensed Embalmer No.....

P. O. Address.....

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.