

Health, Welfare, Public Service

FILED MAR 31 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008878  
STATE FILE NUMBER 333

Registration District No. 42 Primary Registration District No. 1000 Registrar's No.

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Harrison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Plythedale
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2		Length of stay in 1b 40 yrs.	d. STREET ADDRESS (If outside, give location) none
			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Albert H. Carter			4. DATE OF DEATH Month Day Year Mar. 24, 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (City and state or country) unknown	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address Records of State Hospital # 2, St. Joseph, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism		INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic Myocarditis	
	DUE TO (c) 4222	unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Patient in State Hospital since 1957 Aug. 7 diagnosis Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 2	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		

20d. INJURY OCCURRED WHILE AT <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 Mar. 23, 1958 to Mar. 23, 1958 and last saw <sup>her</sup> him alive on Mar. 23, 1958 Death occurred at 6:35 AM on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) M. Thair M.D. R.R.P.	22b. ADDRESS State Hosp # 2 St Joseph Mo	22c. DATE SIGNED 3-24-58

23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE Mar. 24, 1958	23c. NAME OF CEMETERY OR CREMATORY Bogges Funeral Home	23d. LOCATION (City, town, or county) (State) Earleville, Missouri
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24. FUNERAL DIRECTOR Maryoffen - Flanagan - St. Joseph Mo	25. DATE RECD. BY LOCAL REG. Mar. 24, 1958	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *L. J. Chaney* .....

\* Licensed Embalmer No. *467* .....

P. O. Address *W. B. ...* .....

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.