

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040678
STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 266

S. 300 4
1-57

1. PLACE OF DEATH a. COUNTY Livingston				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Livingston			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Chillicothe		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Susan's Nursing			Length of stay in 1b 3 yrs.	d. STREET ADDRESS Susan's Nursing Home		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT SHARP CARR				4. DATE OF DEATH November 19 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1866	9. AGE (In years last birthday) 92		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hoisting Engineer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Muscatine, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME THOMAS CARR		13b. MOTHER'S MAIDEN NAME ISABELLE SWARGRIGG		14. NAME OF HUSBAND OR WIFE Sadie Milliorn			
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. NONE	17. INFORMANT Address ROBERT H. CARR MUNCIE, KANSAS				
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>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH 36 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Vascular Accident (Thrombosis)</u>						72 hrs.	
DUE TO (c) <u>Generalized Arteriosclerosis</u>						Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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.)				
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 <u>July 1955</u> to <u>Nov 19, 1958</u> and last saw her alive on <u>Nov 18, 1958</u> Death occurred at <u>Six Thirty</u> P on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>William J. Fair, M.D.</u>				22b. ADDRESS <u>Chillicothe, Mo</u>		22c. DATE SIGNED <u>11/21/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-22-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood Cemetery</u>		23d. LOCATION (City, town, or county) <u>Chillicothe, Missouri</u>		(State)
24. FUNERAL DIRECTOR ADDRESS <u>NORMAN FN'L HOME: Chillicothe, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>11/21/58</u>		26. REGISTRAR'S SIGNATURE <u>Francis B Neill</u>		

(Licensed Embalmer's Statement on Reverse Side)

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

DEC 8 1958

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 *Elton T. Namm*

Licensed Embalmer No. *4036*

P. O. Address *Chillicothe, 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.