

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000261

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 124

FILED FEB 9 1959

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>Gallatin</u> <u>0310</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital # 2</u>		d. STREET ADDRESS (If outside, give location) <u>General Delivery</u>	
Length of stay in lb <u>1 week</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>A.</u> Last <u>CARTER</u>			4. DATE OF DEATH <u>Feb. 2, 1959</u> Month <u>Feb.</u> Day <u>2</u> Year <u>1959</u>		
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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>October 22, 1873</u>	9. AGE (In years (last birthday)) <u>85</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired electrician</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Gallatin, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Not known</u>	13b. MOTHER'S MAIDEN NAME <u>Catherine Britten</u>	14. NAME OF HUSBAND OR WIFE <u>Nora Walker Carter</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	16. SOCIAL SECURITY NO. <u>not known</u>	17. INFORMANT <u>Records, State Hosp. # 2</u> Address <u>St. Joseph, Mo.</u>
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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>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>42c1</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.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Gallatin, Mo.</u> COUNTY _____ STATE _____
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21. I attended the deceased from <u>Jan 27, 1959</u> to <u>Feb. 2, 1959</u> and last saw him alive on <u>Feb. 2, 1959</u> Death occurred at <u>3:50 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Mohammad Tahiri M.D.</u>	22b. ADDRESS <u>St. Joseph, Mo. State Hospital # 2</u>	22c. DATE SIGNED <u>Feb. 2, 59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brown Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Gallatin, Mo.</u>
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24. FUNERAL DIRECTOR <u>Clark & Clark</u> ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 4, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
Dr. Mohammad Tahiri

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

FEB 11 1959

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 *Earl Clark*

Licensed Embalmer No. *4338*

P. O. Address *St. Joseph*

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.