Health, & Welfare Public Service

. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-017184
STATE FILE NUMBER

FILED JUN 15 1959 Registration District No. 93 Primary Registration District No. Registrar's No. 59-45

1. PLACE OF DEATH
a. COUNTY: Dade
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Lockwood — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Memorial Hosp — Length of stay in Hospital: 9 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Lawrence
c. CITY OR TOWN: Miller — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Tammie Middle: Last: Carter

4. DATE OF DEATH: Month 5 Day 30 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 6-21-1880
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Polk Co.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Deacon Gulick
13b. MOTHER'S MAIDEN NAME: Mattie Danforth
14. NAME OF HUSBAND OR WIFE: Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Helen Simpson Address: Miller Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory Failure — INTERVAL BETWEEN ONSET AND DEATH: 10 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Hemorrhage — 10 days.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 5/20/59, to 5/30/59 and last saw (her/him) alive on 5/29/59
Death occurred at 3:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Elmer W. Taylor M.D.
22b. ADDRESS: Lockwood, Mo
22c. DATE SIGNED: 6/1/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-1-1959
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Red Oak
23d. LOCATION (City, town, or county) (State): Mt. Miller Mo.

24. FUNERAL DIRECTOR: Morris Leisure ADDRESS: Miller Mo.
25. DATE REC'D BY LOCAL REG.: 6/9/1959
26. REGISTRAR'S SIGNATURE: J. C. Canada

(Licensed Embalmer's Statement on Reverse Side)

Elmer W. Taylor, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. R. Leiman

Licensed Embalmer No. 3297

P. O. Address Willow 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.