

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-031721**

**FILED VS. OCT 23 1959**

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 70

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Carrollton</u>		Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>Carrollton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laucaster Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>406 E. Benton</u>		
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>E.</u> Last <u>STATON</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 23 1888</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		9. AGE (last birthday) <u>74</u>		IF UNDER 1 YEAR Months _____ Days _____	
11. BIRTHPLACE (City and state or country) <u>Carroll Co. Mo. U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>M. M. Winfrey</u>			13b. MOTHER'S MAIDEN NAME <u>Ellen Circle</u>			14. NAME OF HUSBAND OR WIFE <u>Oliver Staton</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>none</u>		17. INFORMANT <u>H.D. Staton, Carrollton Mo.</u>	
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>Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</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>Generalized Arteriosclerosis</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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>May 1958</u> to <u>October 4, 1959</u> and last saw her <u>him</u> alive on <u>October 4, 1959</u> Death occurred at <u>9:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>John H. Platy MD</u>				22b. ADDRESS <u>Carrollton, Missouri</u>		22c. DATE SIGNED <u>10-6-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-6-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Carrollton Mo.</u>	
24. FUNERAL DIRECTOR <u>Gibson Funeral Home, Carrollton Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>10-8-59</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Herbert C. Reed</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Ben W. Gibson*

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.