

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035472

FILED VS OCT 26 1959

Registration District No. 55 Primary Registration District No. 5200 Registrar's No. 74

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) OR TOWN <u>Wakenda Twp.</u>		Length of stay in 1b	c. CITY OR TOWN <u>Bogard</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1/2 mi. S. of Carrollton</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u></u>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>W.</u> Last <u>ENYART</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u></u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Stephen B. Enyart</u>		13b. MOTHER'S MAIDEN NAME <u>Narcissus Cobb</u>		14. NAME OF HUSBAND OR WIFE <u>Ida H. Enyart</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes Spanish American</u>			16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Mrs. E.E. Isle, Carrollton Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Broken Neck</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Broken Back Fracture of both</u>		
DUE TO (c) <u>legs below the knee.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Struck by auto 3/10 of mile south of</u>	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	<u>Junction highways 24th and Mo 70. 10th</u>		
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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u> STATE <u></u>

21. I attended the deceased from 10-23-59 to 10-23-59 and last saw her/him alive on
Death occurred at 5:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. M. Marshall, Jr. Coroner</u>		22b. ADDRESS <u>Carrollton Mo</u>	22c. DATE SIGNED <u>10-23-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-25-59</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>	ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>10-23-59</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Herbert Calvert</u>

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

SA
OCT 28 1959

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. Gibbs

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.