

# FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 27 1959

59-037145

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 122

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Pike</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Louisiana</u> Length of stay in 1b <u>2 weeks</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pike County Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Pike</u> c. CITY OR TOWN <u>Curryville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>-----</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>DORA</u> Middle <u>MAE</u> Last <u>CARTER</u>				<b>4. DATE OF DEATH</b> Month <u>Oct.</u> Day <u>16</u> Year <u>1959</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug 28 1886</u>		<b>9. AGE</b> (last birthday) <u>73</u>		<b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>18</u>		<b>IF UNDER 24 HR</b> Hours <u>-----</u> Min. <u>-----</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>		<b>11. BIRTHPLACE</b> (City, and state or country) <u>Martinsburg, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>US</u>					
<b>13a. FATHER'S NAME</b> <u>Henry Hockaday</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>Julia Soil</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>Howard Carter</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>494 32 4340</u>		<b>17. INFORMANT</b> <u>Howard Carter, Curryville, Mo.</u> Address <u>-----</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> DUE TO (b) <u>Hypertensive cardio-vascular disease with auricular fibrillation, Cardiac hypertrophy, Dilatation, Pulmonary Congestion, Pleural Effusion</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>-----</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>8 yrs 1mth.</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>-----</u>									
<b>20c. TIME OF INJURY</b> Hour <u>-----</u> a.m. <u>-----</u> p.m. <u>-----</u>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-----</u>		<b>20f. CITY, TOWN, OR LOCATION</b> <u>-----</u>		<b>COUNTY</b> <u>-----</u>		<b>STATE</b> <u>-----</u>			
<b>21. I attended the deceased from</b> <u>10/2/59</u> to <u>10/16/59</u> and last saw her/him alive on <u>10/16/59</u> Death occurred at <u>6:20</u> P m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <u>Chas H. Sewell</u> M.D.				<b>22b. ADDRESS</b> <u>Louisiana, Missouri</u>				<b>22c. DATE SIGNED</b> <u>10/17/59</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>Oct 20 59</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Martinsburg Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Martinsburg Mo.</u>							
<b>24. FUNERAL DIRECTOR</b> <u>J.O. Mudd</u> ADDRESS <u>Bowling Green, Mo.</u>		<b>DATE RECD. BY LOCAL REG.</b> <u>Oct 20, 1959</u>		<b>24. REGISTRAR'S SIGNATURE</b> <u>Bernice Collier</u>									

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 10 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 James O. Mudd  
Licensed Embalmer No. 4152

P. O. Address Beavering

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.