

St. Health,  
& Welfare  
S. Public  
H Service

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED VS AUG 12 1960

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-026657  
STATE FILE NUMBER

Registration District No. 382 Primary Registration District No. 4230 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <u>Howard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Armstrong</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Armstrong 0450,</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR RESIDENTIAL <u>Peace Rest Home</u>		Length of stay in lb <u>5 YRS.</u>		d. STREET ADDRESS (If outside give location) <u>Peace Rest Home</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Bert Carnes</u>				4. DATE OF DEATH Month Day Year <u>July-20-1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 9-1882</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS <u>77</u> Months <u>10</u> Days <u>11</u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Linn Creek, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Jonathon Carnes</u>			13b. MOTHER'S MAIDEN NAME <u>Liza Jefferies</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service) <u>NO</u>			16. SOCIAL SECURITY NUMBER <u>NONE</u>		17. INFORMANT Address <u>Mrs. Walter Recker, Centralia, 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>Chronic congestive heart failure</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) <u>Arteriosclerotic heart disease</u>						<u>unknown</u>	
DUE TO (c) <u>4200</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
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. Month, Day, Year p.m.							
20d. INJURY OCCURRED WHILE AT <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		COUNTY STATE	
21. I attended the deceased from <u>Sept 11 1956</u> to <u>July 20 1960</u> and last saw her/him alive on <u>June 29 1960</u> Death occurred at <u>June 20 1960 6:00 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Francis J. Lam M.D. Fayette, Mo.</u>				22b. ADDRESS		22c. DATE SIGNED <u>8-3-61</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>July 22-1960</u>	<u>Centralia Cemetery</u>		<u>Centralia, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Paul C. Ballou, Centralia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Aug. 5, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Walker Audsley</u>	

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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 *Paul D. Ballew* .....

Licensed Embalmer No. *4206* .....  
P. O. Address *Centralia, 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.