URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-035594

STATE FILE NUMBER

FILED VS SEP 26 1960

NDED

Registration District No. 245 Primary Registration District No. 5834 ~~5835~~ Registrar's No. 93

1. PLACE OF DEATH
a. COUNTY: Newton
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Marion Twsp.
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: West Union Rest Home
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Lawrence
c. CITY OR TOWN: Wentworth
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): Route # 1
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Carl Middle: Lee Last: Staples

4. DATE OF DEATH: Month: Sept. Day: 7 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 9-13-1877

9. AGE (last birthday): 82

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (City and state or country): Ky.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Sanford B. Staples

13b. MOTHER'S MAIDEN NAME: Annie Kemp

14. NAME OF HUSBAND OR WIFE: Nellie Staples

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Glenn Staples, K. C. Mo. Address

MEDICAL CERTIFICATION

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)	Pulmonary Oedema	24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Myocarditis, chronic	1 year
DUE TO (c)	Arteriosclerosis	3 years

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 1 Jan 1955, to 9-7-60 and last saw ~~him~~ her alive on 7 Sept 1960

Death occurred at 9:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Leroy Simmons (Degree or title) M.D.

22b. ADDRESS: Sarcoxie, Mo.

22c. DATE SIGNED: 8 Sept 60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 9-10-60

23c. NAME OF CEMETERY OR CREMATORY: Sarcoxie Cemetery

23d. LOCATION (City, town, or county) (State): Sarcoxie, Mo.

24. FUNERAL DIRECTOR ADDRESS: Ulmer-Moss Funeral Home, Sarcoxie, Mo.

25. DATE RECD. BY LOCAL REG.: 9/17/60

26. REGISTRAR'S SIGNATURE: Melvin C. Bowman, M.D. per RH.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

SEP 2 6 1960

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_____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4953

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.