

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960 38

=60-045120

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 692

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>3 weeks 1 da.</u>		c. CITY OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>703 Fay St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES SR. CARTER</u>				4. DATE OF DEATH Month Day Year <u>Dec. 10 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</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>Dec. 19, 1867</u>	9. AGE (last birthday) <u>92 yr.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state of country) <u>Boone County Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <u>Henry Carter</u>		13b. MOTHER'S MAIDEN NAME <u>Celia Hickman</u>		14. NAME OF HUSBAND OR WIFE <u>Annie Carter</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>49-42-23775A</u>	17. INFORMANT Address <u>James Carter Jr. Columbia, 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>Ventricular Fibrillation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11/17/60</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Complete Heart Block</u>	
						DUE TO (c) <u>Arteriosclerotic Heart Disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Hemorrhage - Left Hemiplegia</u>						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 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 Month, Day, Year a.m. p.m.							
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>November 17, 1960</u> to <u>December 10, 1960</u> and last saw <sup>her</sup> him alive on <u>December 9, 1960</u> Death occurred at <u>2:50 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Robert L. Wiggins, M.D.</u>				22b. ADDRESS <u>201 N. Presidentia Columbia, Mo.</u>		22c. DATE SIGNED <u>12/10/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>12/14/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Celvary</u>		23d. LOCATION (City, town, or county) <u>Columbia, Mo.</u>			
24. FUNERAL DIRECTOR <u>Mrs. Stuart Parker, Columbia, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Dec 14 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>		

ENDED

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 George P. Tramm

Licensed Embalmer No. 4425

P. O. Address Columbus, Ga.

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.