

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-027597

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 160 Primary Registration District No. 559 Registrar's No. 107

1. PLACE OF DEATH a. COUNTY JEFFERSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JEFF.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RURAL JOACHIM		c. CITY OR TOWN FESTUS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION JEFF. CO. HOSPITAL		d. STREET ADDRESS (If outside, give location) 509 N. 4th. ST.	
3. NAME OF DECEASED (Type or print) JAMES T. CARR		4. DATE OF DEATH Month 7 Day 22 Year 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-26-1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GLASS WORKER		10b. KIND OF BUSINESS OR INDUSTRY P.P.G. CO.	11. BIRTHPLACE (City and state or country) JEFFERSON CO. MO.
13a. FATHER'S NAME JOHN T. CARR		13b. MOTHER'S MAIDEN NAME OLLIE THOMPSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) YES WW2		17. INFORMANT Address MRS J. T. CARR FESTUS, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH Threedays
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"/>		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>7-19-62</u> to <u>7-22-62</u> and last saw him alive on <u>7-22-62</u> Death occurred at <u>7:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>R. D. [Signature]</i>		22b. ADDRESS <i>112 Miss Ave, Crystal City, Mo</i>	
22c. DATE SIGNED <i>7/23/62</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7-25-62	23c. NAME OF CEMETERY OR CREMATORY ROSELAWN GARDEN	23d. LOCATION (City, town, or county) (State) CRYSTAL CITY, MO.
24. FUNERAL DIRECTOR ADDRESS GENTRY R. POLITTE CRYSTAL CITY, MO.		25. DATE RECD. BY LOCAL REG 7-24-62	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

DATE AMENDED

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59
0.500
20.506
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94201
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AUG 3 1962

AUG 3 0 1962

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

Gentry R. Plitte

Licensed Embalmer No.

3481

P. O. Address

Crystal City - 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.