

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031908

STATE FILE NUMBER

Registration District No. 201 Primary Registration District No. 3048 Registrar's No. 203

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

6745
20745

3

4 1

5 1

6

7 1

8 0

9 420.1

10

11

12 2-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>NODAWAY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>NODAWAY</u>	
b. CITY (If outside corporate limits, give township only) OR TOWN <u>MARYVILLE</u> <u>1 wk.</u>		c. CITY OR TOWN <u>MARYVILLE</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>ST FRANCIS Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>602 S Birch-</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISE G. CARTER</u>		4. DATE OF DEATH Month Day Year <u>8-13-62</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-1887-75</u>
9. AGE (last birthday) <u>75</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME-OWN</u>	
11. BIRTHPLACE (City and state or country) <u>CRISTON, IOWA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13a. FATHER'S NAME <u>JAMES L. McCANN</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA MULLEN</u>	
14. NAME OF HUSBAND OR WIFE <u>E.B. "BERT" CARTER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No.</u>	
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>E.B. "BERT" CARTER, MARYVILLE</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>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Occlusion</u>		DUE TO (c) <u>Coronary Atherosclerosis?</u>	
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"/>	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		20d. INJURY OCCURRED WHILE AT WORK <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>8/7/62</u> to <u>8/13/62</u> and last saw her alive on <u>8/13/62</u> Death occurred at <u>1:52 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Maryville, Mo</u>	
22c. DATE SIGNED <u>8/14/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-16-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Columba Cem</u>	
23d. LOCATION (City, town, or county) (State) <u>CONCEPTION - MO.</u>			
24. FUNERAL DIRECTOR <u>ATCHISON-MARYVILLE, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-14 62</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

USE BLACK INK OR TYPEWRITER RIBBON

7081 AOW

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 G M Atchman

Licensed Embalmer No. 3279
P. O. Address Maryville 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.