

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-021033

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 68

FILED MAY 21 1963

VS 300
Rev. 4/59

10820

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
(INSTEAD OF)

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Pike		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pike	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clarksville		Length of stay in 1b 50 years	c. CITY OR TOWN Clarksville Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Delivery		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) General Delivery Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Floyd Scott Carroll			4. DATE OF DEATH Month Day Year May 6 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/19/82
9. AGE (last birthday) 81		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) Farming		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and state or country) Pearl, Illinois
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Lyman Carroll	
13b. MOTHER'S MAIDEN NAME Sarah Ottwell		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Dorothy Barnes, Rock Island, Ill.
18. CAUSE OF DEATH (Enter only one cause per item) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive heart failure arteriosclerotic heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 hours unknown
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 a.m. p.m. Month, Day, Year	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 3 hours before death to death and last saw her ^{her} alive on 5-6-63 Death occurred at 120 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Edmund K. Jackson, M.D.		22b. ADDRESS Clarksville Mo.	22c. DATE SIGNED 5/7/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/8/63	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) Clarksville, Missouri
24. FUNERAL DIRECTOR Sterne Funeral Home, Louisiana, Missouri		25. DATE RECD. BY LOCAL REG. 5-20-63	26. REGISTRAR'S SIGNATURE Bernice Collins

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 J.B. Starnel

Licensed Embalmer No. 4039

P. O. Address Louisiana 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.