

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 350030813 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>MONTEAU</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Jefferson City</u>		c. CITY OR TOWN <u>Califortnia</u>	
Length of stay in 1b <u>5 days</u>		d. STREET ADDRESS (If outside, give location) <u>St Marys Hospital</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>St Marys Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>POWERS</u> Last <u>CARR</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>1</u> Year <u>1964</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</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>2-6-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Master</u>		11. BIRTHPLACE (City and state or country) <u>Welsh Louisiana</u>	
13a. FATHER'S NAME <u>W. E. CARR</u>		14. NAME OF HUSBAND OR WIFE <u>MADE CHANEY CARR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>U.S. National Guard</u>		16. SOCIAL SECURITY NO. <u>496-48-5435</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>Cerebral Vascular Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>30 DAYS</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 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 <u>Jan. 1962</u> to <u>Sept 1, 1964</u> and last saw him alive on <u>Aug 31, 1964</u> Death occurred at <u>6:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>S Sanders MD</u> (Degree or title)		22b. ADDRESS <u>515 E. High, Jefferson City</u>	
22c. DATE SIGNED <u>9/2/64</u>		22d. LOCATION (City, town, or county) (State) <u>Califortnia Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-3-1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Califortnia Mo</u>
24. FUNERAL DIRECTOR <u>Hugh E. Williams</u>		25. DATE REC'D. BY LOCAL REG. <u>3 September 1964</u>	
ADDRESS <u>California Mo</u>		26. REGISTRAR'S SIGNATURE <u>Theresa E. Risher</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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SEP 9 1964

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 Richard D. Conn

Licensed Embalmer No. 4703

P. O. Address Lipton, 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.