TYPE/PRINT IN PERMANENT BLACK INK. FOR INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK.

LTIC# 55376

93041047

MISSOURI DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER

REGISTRATION DISTRICT NO 019 REGISTRAR'S NUMBER 928 124 -

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM CHARLES CARLSON
2. SEX: MALE
3. DATE OF DEATH (Month, Day, Year): July 17, 1992
4. SOCIAL SECURITY NO: 350-12-7685
5a. AGE - Last Birthday (years): 67
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Month, Day, Year): NOVEMBER 11, 1924
7. BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] Yes [ ] No [ ] Unk
9a. PLACE OF DEATH (check only one, see instructions on other side): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA OTHER: [ ] Nursing Home [ ] Residence [ ] Other (specify)
9b. FACILITY NAME (If not institution, give street and number): BOONE HOSPITAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA
9d. COUNTY OF DEATH: Boone
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name): MARY E. BURNAM
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): LABORER
12b. KIND OF BUSINESS OR INDUSTRY: U.S. STEEL
13a. RESIDENCE - STATE: MISSOURI
13b. COUNTY: MACON
13c. CITY, TOWN OR LOCATION: BEVIER
13d. ZIP CODE: 63532
13e. STREET AND NUMBER: 541 NORTH BLOOMINGTON
13f. INSIDE CITY LIMITS: [X] Yes [ ] No
13g. YEARS AT PRESENT ADDRESS: [ ] Under 5 [X] 5-9 [ ] 10-19 [ ] 20 or more
14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes Specify:
15. RACE - American Indian, Black, White, etc. (Specify): WHITE
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): --

NAME OF DECEDENT: William Carlson

VS 300 Rev. 1-90 MO 580 (4-90)

PARENTS

17. FATHER'S NAME (First, Middle, Last): CHARLES F. CARLSON
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET CARLSON

INFORMANT

19a. INFORMANT'S NAME (Type/Print): MARY CARLSON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 541 NORTH BLOOMINGTON, BEVIER, MISSOURI 63532

DISPOSITION

20a. BURIAL, CREMATION, OTHER (Specify): CREMATION
20b. DATE OF DISPOSITION (Month, Day, Year): JULY 17, 1992
20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): PARKER CREMATORY
20d. LOCATION - City or Town, State: COLUMBIA, MISSOURI
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: Bruce B. Lee
22a. NAME AND ADDRESS OF FACILITY: PARKER FUNERAL SERVICE P.O. BOX 1251 COLUMBIA, MO 65205
22b. FUNERAL ESTABLISHMENT LICENSE NUMBER: 431

SEE INSTRUCTIONS ON OTHER SIDE

CAUSE OF DEATH

23. PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Metastatic Undifferentiated Carcinoma
DUE TO (OR AS A CONSEQUENCE OF)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? [ ] Yes [ ] No [ ] Unk.
25a. WAS AN AUTOPSY PERFORMED? [ ] Yes [X] No
25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [ ] Yes [ ] No
26. MANNER OF DEATH: [X] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
27a. DATE OF INJURY (Month, Day, Year)
27b. TIME OF INJURY M
27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) [ ] Yes [ ] No [ ] Unk
27d. INJURY AT WORK? [ ] Yes [ ] No [ ] Unk
27e. DESCRIBE HOW INJURY OCCURRED
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)
27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)

CERTIFIER

28a. (Specify) [ ] CERTIFYING PHYSICIAN [X] MEDICAL EXAMINER/CORONER
28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) ▶ Edward H Adelstein MD
28c. DATE SIGNED (Month, Day, Year): 7-17-92
28d. TIME OF DEATH: 2:05 A M
29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print): Edward H. Adelstein, M.D.,M.E. Columbia, MO
29b. MO LICENSE NUMBER: 32546
30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? [X] Yes [ ] No
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)
32. REGISTRAR'S SIGNATURE: Michael R. Sanford by D Boise
33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year): 7/17/92

FILED JUN 16 1993 Anna M. Anton AUDITOR LAKE COUNTY

93 JUN 15 PM 2:14 RECORDER LAKE COUNTY FILED FOR RECORD

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STATE OF MISSOURI } ss

I HEREBY CERTIFY that this is an exact reproduction of the certificate for the person named therein as it now appears in the permanent records of the Bureau of Vital Records of the Missouri Department of Health. Witness my hand as County Registrar of Vital Statistics and the Seal of the Missouri Department of Health this date of

7-17-92

Michael R. Sanford
Registrar of Vital Statistics

MO 580-1103 (7-89)