

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County <u>Gasconade</u>	Registration District No. <u>302</u>	File No. <u>231539</u>	
Township <u>Clay</u>	Primary Registration District No. <u>6231</u>	Registered No. _____	
Village _____			
City _____	(No. _____ St. _____ Ward _____)		(If death occurred in a hospital or institution, give its NAME instead of street and number)
FULL NAME <u>Lydia M. Carroll</u>			
PERSONAL AND STATISTICAL PARTICULARS		3 MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>white</u>	DATE OF DEATH <u>September 18</u> , 191 <u>7</u> (Month) (Day) (Year)	
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>		I HEREBY CERTIFY, that I attended deceased from <u>March 1</u> , 191 <u>7</u> , to <u>Sept 13</u> , 191 <u>7</u> , that I last saw her alive on <u>September 6</u> , 191 <u>7</u> , and that death occurred, on the date stated above, at <u>3 p.</u> m.	
DATE OF BIRTH <u>January 2</u> , 18 <u>80</u> (Month) (Day) (Year)		The CAUSE OF DEATH* was as follows: <u>Sarcoma of left arm under vein. Two surgical operations last was an</u>	
AGE <u>37</u> yrs. <u>7</u> mos. <u>17</u> ds.	If LESS than 1 day, _____ hrs. or _____ min.?	<u>Sarcoma of left arm under vein. Two surgical operations last was an</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u>		Contributory <u>Hereditary predisposition</u> (Duration) _____ yrs. _____ mos. _____ ds.	
(b) General nature of industry, business, or establishment in which employed (or employer) <u>" " 53E</u>		(Signed) <u>John D. Seba</u> M. D. <u>Sept 12</u> , 191 <u>7</u> (Address) <u>Bland, Mo</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Osage Co. Mo 156</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS	NAME OF FATHER <u>Harm Baker</u>	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Osage Co. Mo</u>	At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER <u>Elisabeth Paniter</u>	Where was disease contracted If not at place of death?	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Osage Co. Mo.</u>	Former or usual residence _____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Darkest Baker</u>		PLACE OF BURIAL OR REMOVAL <u>New Bethel Cemetery</u> DATE OF BURIAL <u>Sept 14</u> 191 <u>7</u>	
(ADDRESS) <u>Bland, Mo. R.F.D. 3.</u>		UNDERTAKER <u>F. W. Kramig</u> ADDRESS <u>Bland, Mo</u>	
Filed <u>Sept. 13</u> 191 <u>7</u> <u>Carbunge M.D.</u> REGISTRAR			

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....

(NO.

Registration District No.

File No.

Primary Registration District No.

Registered No.

St. Ward)

If death occur
hospital or in
give its NAME
of street and no.

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX.....COLOR OR RACE.....
SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

(Month).....(Day).....(Year).....

AGE

.....yrs.....mos.....ds.
IF LESS than
1 day.....hrs
or.....min.?

OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

BIRTHPLACE

(City or town,
State or foreign country)NAME OF
FATHERBIRTHPLACE
OF FATHER

(City or town, State or foreign country)

MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

191.....

REGISTRAR

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Revised United States Standard

"Typhoid pneumonia"); Lobar pneumonia; Broncho-

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month).....(Day).....

I HEREBY CERTIFY, that I attended deceased

....., 191....., to

that I last saw h.....alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration).....yrs.....mos.....

Contributory

(SECONDARY)

(Duration).....yrs.....mos.....

(Signed)

191.....(Address)

*State the Disease Causing Death, or, in deaths from Violent Causes,
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENT
RECENT RESIDENTS)At place.....yrs.....mos.....ds. State.....yrs.....mos.....
In theWhere was disease contracted
if not at place of death?Former or
usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS