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

Do not use this space.

11227

1. PLACE OF DEATH

County Clay Registration District No. 198 File No.

Township ~~Fishing~~ River Primary Registration District No. 3011 Registered No. 42

City Ex Spgs (No. ..... St. ..... Ward)

2. FULL NAME Please Carver

(a) Residence. No. Ex Spgs Sanitarium Ward. Eolia Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Cecella Carver

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 23 - 1868

7. AGE: Years 58 | Months 8 | Days 16 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) General farming
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Eolia Mo
(STATE OR COUNTRY) Pike Co

PARENTS

10. NAME OF FATHER Ruben Carver
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Pike Co
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Dont Know

14. INFORMANT G. D. Sisson
(Address) Louisina Mo

15. FILED 4/10, 1927 Y. D. Craven
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1927, to April 9, 1927, that I last saw him alive on April 9, 1927, and that death occurred, on the date stated above, at 9 p.m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pernicious Anemia

NA

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 58A

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no. DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Blood Examination Gastric Analysis

(Signed) J. E. Musgrave, M. D

, 19 (Address) Excelsior Springs Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Clarksville Mo.
DATE OF BURIAL: April 12 1927

20. UNDERTAKER: John C Prather
ADDRESS: Ex Spgs

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.

MAY 26 1927

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

Do not use this space. April cert.

1. PLACE OF DEATH

County: Clay

Township:

City: Excelsior Springs (No. ..... St. ..... Ward)

Registration District No. 198

Primary Registration District No. 3011

File No.

Registered No. 42

2. FULL NAME: Please Correct

(a) Residence. No. ..... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 23, 1862

7. AGE: Years 65 | Months 8 | Days 16 | If LESS than 1 day, ... hrs. ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 4/10, 1927 Y. D. Craven
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 9, 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw he alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(SECONDARY)

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? ..... DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ....., M. D
, 19 . (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTAL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT R

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.

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