

OCT 24 1927

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

Do not use this space.

26633

1. PLACE OF DEATH

County Butter
Township Ark Hill
City (No. _____) _____ St. _____ Ward _____

Registration District No. 925
Primary Registration District No. 5134

File No. _____
Registered No. 18

2. FULL NAME

Floyd Levell Carroll
(a) Residence No. _____ St. _____ Ward Broseley, 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 12, 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
— 7 10

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) Broseley, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Buck Carroll

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Butter City, Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

14. INFORMANT Buck Carroll
(Address) Broseley

15. FILED 9/21, 1927 Carroll & Heathorn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/22 19 27

17. I HEREBY CERTIFY, That I attended deceased from 9/18, 1927, to 9/21, 1927, that I last saw him alive on 9/21, 1927, and that death occurred, on the date stated above, at about 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Indigestion
1186
(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) _____
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. P. Heathorn, M. D.

(Address) 725 E. 2nd

*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 Mole Hill - DATE OF BURIAL 9/24 19 27

20. UNDERTAKER Frank Undertaking ADDRESS Poplar Bluff

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

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REPORT NO. 101...
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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Buena Vista Registration District No. 925 File No. _____
 Township Ash Hill Primary Registration District No. 5734 Registered No. 18
 City _____ (No. _____) _____ St. _____ (Ward _____)

2. FULL NAME Floyd Lowell Carroll
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.

B. 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) _____

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 22 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intoxication over feeding

CONTRIBUTORY (SECONDARY) 1/20 (duration) _____ yrs. _____ mos. _____ da.

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. (See reverse side for additional space.)

14. INFORMANT (Address) _____

15. FILED 9/21 1927 Vincent Gresham REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ **DATE OF BURIAL** _____

20. UNDERTAKER _____ **ADDRESS** _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

CAUSE OF DEATH should state CAUSE OF DEATH. If cause of death is classified

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