

MAR 19 1928

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

Do not use this space.

1. PLACE OF DEATH

County Dallas
Township Wilson
City Long Grove (No.)

Registration District No. 247
Primary Registration District No. 5343

File No. 4456
Registered No.
St. Ward

2. FULL NAME

Champ D. Carr

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>S</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>7/6/1900</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>28</u>		<u>13</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labauer
(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) Mo.

10. NAME OF FATHER C S Carr
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Hawerton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

14. INFORMANT C. S. Carr
(Address) Long Lake, Mo.

15. FILED 3-10-28
J. J. Salbot
REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/29 1928
17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1928, to Feb 29, 1928 that I last saw him alive on Feb 27, 1928, and that death occurred, on the date stated above, at 5 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Phthisis Pulmonalis
23A
..... (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 31
..... (duration) yrs. mos. ds.

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) M. D.
, 19 (Address) Buffalo, 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 New Hope DATE OF BURIAL 3/1 1928
20. UNDERTAKER B. C. Routh & Son ADDRESS Buffalo, Mo.

N. B.—Every item of information should be carefully checked for exactness. EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be readily understood. Exact statement of OCCUPATION is very important.

**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 Dallas Registration District No. 247 File No. 4456
 Township Wilson Primary Registration District No. 5343 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Champ D. Carr

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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.

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) _____

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 3-10-1928

D. Galbot
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-29 19 28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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) D. Galbot, M. D. (Address) Long Lane 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 _____

DATE OF BURIAL _____

20. UNDERTAKER _____

ADDRESS _____

19

PERMANENT RECORD
 Fully supplied. AGE
 term of information should be carefully reported. Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. STATE IN plain terms, so that it may be properly classified.
 SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

