

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

Do not use this space.

31112

1. PLACE OF DEATH

County Miller
 Township Salon
 City Eldon

Registration District No. 561
 Primary Registration District No. F330

File No. _____
 Registered No. 60
 St. _____ Ward _____

2. FULL NAME Tobias Carico

(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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-12-1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
60 9 7

8. OCCUPATION OF DECEASED Farmer
 (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) Miller Co. Missouri
 (STATE OR COUNTRY)

10. NAME OF FATHER John Carico

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

12. MAIDEN NAME OF MOTHER Margaret Carico

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

14. INFORMANT John Carico
 (Address) Elmer Mo

15. FILED Sept 20 1928 Welle Hayes
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 19 1928

17. I HEREBY CERTIFY, That I attended Sept 19 to Sept 19 1928 that I last saw him alive on Sept 18, 1928, and that death occurred, on the date stated above, at 6 p. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Mitral Lesion
compensating & dilated
Heart

923 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 900 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 900
 IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? W. F. Allen, M. D.

(Signed) _____, 19 _____ (Address) Eldon 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 Godt Cemetery DATE OF BURIAL Sept 21 1928

20. UNDERTAKER James Funeral Home Eldon Mo ADDRESS

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.

