

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

Do not use this space.

9858

1. PLACE OF DEATH

County Carroll

Registration District No. 135

File No. _____

Township _____

Primary Registration District No. 3034

Registered No. 34

City Carrollton (No. _____)

St. _____ Ward _____

2. FULL NAME

Carol Louise Cary

(a) Residence. No. _____ St. _____ Ward _____

(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

F

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)

5-28-1928

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, _____ hrs. or _____ min.

9 | 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Carrollton

(STATE OR COUNTRY)

Mo

10. NAME OF FATHER

Robert J. Cary

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Carrollton

(STATE OR COUNTRY)

Mo

12. MAIDEN NAME OF MOTHER

Nanning Burton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Buchannon Co.

(STATE OR COUNTRY)

Mo

14. INFORMANT

Robert Cary

(Address)

Carrollton Mo

15. FILED

3-26 1929 Mrs. E. E. Farham

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

3-26 1929

17.

I HEREBY CERTIFY, That I attended deceased from 3 24, 1929 to 5 26, 1929, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia, lobular
following measles
10 27 (duration) yrs. mos. ds.
10 27 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) W. H. [Signature]

M. D.

3-26 1929 (Address) Carrollton 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

Oak Hill Cem.

3-28 1929

20. UNDERTAKER

L. Landley

ADDRESS

Carrollton

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

Y. P. VAICIBS
State of New York

of the State of New York

R. M. Benson (Carrington)

157

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

4 80 8
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Carroll Registration District No. 135- File No.
Township Primary Registration District No. 3031 Registered No. 34
City Carrolleton (No.) St. Ward)

2. FULL NAME

Carol Louise Cary
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (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)

INFORMANT (Address) 1

15. FILED 19 Mrs E E Jarboe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-26-1929

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:

One pneumonia lobular following measles

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

20. UNDERTAKER ADDRESS

ALL INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE THIS IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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