

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

Do not use this space.

23665

1. PLACE OF DEATH

County Webster Registration District No. 900
Township Mangrove Primary Registration District No. 6207
City (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
18 | do not know

8. OCCUPATION OF DECEASED exact date of Birth

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) no close relatives who know
(c) Name of employer

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

10. NAME OF FATHER James Carroll

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no

12. MAIDEN NAME OF MOTHER don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no

14. INFORMANT James Carroll (Address)

15. FILED July 9 29 D. A. Williams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

had no phy but
11/4/13 suppose abscess
embolus

CONTRIBUTORY (SECONDARY) embolus

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? no
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 Mangrove Cemetery DATE OF BURIAL July 12 29

20. UNDERTAKER See Bolin Mangrove ADDRESS _____

Every item of information should be carefully supplied. OF DEATH in plain terms, so that it may be properly understood.

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

6-29
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Webster Registration District No. 900 File No. _____
Township Manqua Primary Registration District No. 6207 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Gilley Carroll
(a) Residence. No. _____ St. _____ Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>S</u> <small>(write the word)</small>
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		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 11 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:

CONTRIBUTORY (SECONDARY)

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) There was no phys 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 Manqua Cemetery DATE OF BURIAL June 12 1929
ADDRESS _____
20. UNDERTAKER Jes Bolin Manqua Mo

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)

INFORMANT James Carroll
(Address) _____
FILED July 9 1929 H. A. Williams
REGISTRAR

SUPPLEMENTARY

N. B.—Very item of information should be stated EXACTLY. AGE should be stated EXACTLY. OCCUPATION should be stated EXACTLY. CAUSE OF DEATH should be stated EXACTLY. If any of these items are not stated, the certificate is invalid. ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

TIL THEY ARE COMPLETE AS PRESCRIBED BY

S-23665