

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

Do not use this space.

At Home 19206
Cramer
File No. _____
Registered No. 21
St. _____ Ward)

1. PLACE OF DEATH

County Boyer Registration District No. 321
Township Clark Primary Registration District No. 5444
City Marion Mo (No. _____) St. _____ Ward)

2. FULL NAME

Mary M. Carnet
(a) Residence. No. _____ 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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 23 1930

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

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____ that I last saw him dead on June 24, 1930, and that death occurred, on the date stated above, at 7 AM m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 3-1930

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
✓ 4 70

Infanticide by drowning in the river, by a demented mother
172 (duration) yrs. mos. ds.

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 _____

CONTRIBUTORY (SECONDARY) 2 1/2 years in attendance
(duration) yrs. mos. ds.

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

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

10. NAME OF FATHER Marion Carnet

18. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

19. WAS THERE AN AUTOPSY? yes

12. MAIDEN NAME OF MOTHER Mary Holt

WHAT TEST CONFIRMED DIAGNOSIS (Signed) Harvey C Stone M. D.

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

June 24, 1930 (Address) Springfield Mo

14. INFORMANT (Address) Marion Carnet
Rome 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.

15. FILED 6/25/30 H. L. Turner REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL (Address) Rome Mo DATE OF BURIAL June 25 1930

20. UNDERTAKER (Address) H. H. Johnson Springfield Mo

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.

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