

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

Do not use this space.

21239 ~~21239~~

1. PLACE OF DEATH

County.....
Township.....
City.....
Registration District No. **791**
Primary Registration District No. **1008**

File No.....
Registered No. **6101**
Ward.....

2. FULL NAME

Prima G Carouthers
(a) Residence. No. **3541 Lafayette Ave 17** 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Middleton Carouthers</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Jan 28 - 1938</i>		
7. AGE	YEARS <i>72</i>	MONTHS <i>4</i>
	DAYS <i>24</i>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Housework</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

2 MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) *June 22 1930*

17. I HEREBY CERTIFY, That I attended deceased from *June 19 1930* to *June 22 1930* that I last saw her alive on *June 22 1930* and that death occurred, on the date stated above, at *10:20 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio Sclerosis
93C
97

Dr. [Signature]
(duration) yrs. mos. ds.

CONTRIBUTORY *Chronic Myocarditis*
(SECONDARY)
Dr. [Signature]
(duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Arkansas*

10. NAME OF FATHER *Alfred Nairmore*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

18. WHERE WAS DISEASE CONTRACTED

AT PLACE OF BIRTH.....
DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS? *smle*
(Signed) *[Signature]* M. D.
6-24, 1930 (Address) *6520 Maple Ave*

14. INFORMANT

(Address) *Frank R. [Signature] 3541 Lafayette Ave*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL *June 25 1930*
Sunset Burial Park

15.

FILED *21 1930*
REGISTRAR *[Signature]*

20. UNDERTAKER

Wacker-Helderle
ADDRESS *2331 S Bldg*

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.

