

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

Do not use this space.

22686
66

1. PLACE OF DEATH

County Howell
Township Howell
City..... (No..... Ward.....)

Registration District No. 384
Primary Registration District No. 5-5-5-1-

File No. 66
Registered No.
St. Ward.....

2. FULL NAME LaVerna June Carpenter

(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. 10 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 25, 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 0 10

8. OCCUPATION OF DECEASED None

- (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) West Plains, Rt 3
(STATE OR COUNTRY)

10. NAME OF FATHER John Carpenter

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

12. MAIDEN NAME OF MOTHER Florence Wright

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

14. INFORMANT Mrs. John Carpenter.
(Address) West Plains, Rt. 3

15. FILED 7-7-1930 O.P. Heinrich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 5 1930

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to July 5, 1930, that I last saw him alive on July 4, 1930, and that death occurred, on the date stated above, at 3:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Congenital atresia of esophagus
(malformation)

157D

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. Claude Bahner M. D.

7-7-1930 (Address) West Plains, 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 Oak Lawn Cemetery DATE OF BURIAL 7/6/ 19 30

20. UNDERTAKER Hal Heimburch ADDRESS West Plains, 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.

AUG 26 1930

WRITE PLAINLY, WITH CRISP LETTERS

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