

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.

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

Do not use this space.

OCT 17 1934

1. PLACE OF DEATH *Pike*  
 County *Pike* Registration District No. *689*  
 Township *Buffalo* Primary Registration District No. *5917*  
 City *Buffalo* (No. *1*) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. *33749*  
 Registered No. \_\_\_\_\_

2. FULL NAME *May Catherine Carr*  
 (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 *17* 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 (write the word) <i>Widow</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>John Rely Carr (Deed)</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>July 10 - 1857</i>		
7. AGE	YEARS <i>77</i>	MONTHS <i>1</i>
	DAYS <i>17</i>	If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>at Home</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Arkansas</i>		
FATHER	13. NAME <i>John Smith</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Tenn</i>	
MOTHER	15. MAIDEN NAME <i>Martha Clark</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Tenn</i>	
17. INFORMANT <i>S. M. Carr</i> (ADDRESS) <i>Bourbon Iowa Mo</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Louisiana Mo</i> DATE <i>Sept. 3 1934</i>		
19. UNDERTAKER <i>H. B. E. Moore</i> (ADDRESS) <i>Bourbon Iowa Mo</i>		
20. FILED <i>9/2</i> 19 <i>34</i> <i>J. H. Kelly</i> Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 2 1934*

22. I HEREBY CERTIFY, That I attended deceased from *June*, 19 *34* to *Sept 2*, 19 *34*  
 I last saw him alive on *Sept 2*, 19 *34* Death is said to have occurred on the date stated above, at *12 A.* m.  
 The principal cause of death and related causes of importance were as follows:  
*Bowel Obstruction, by 31 perfectly interrupted*  
*12 A. P. M.*  
 Other contributory causes of importance  
*None*  
 Name of operation *no* Date of \_\_\_\_\_  
 What first confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? *no*  
 If so, specify \_\_\_\_\_  
 (Signed) *J. M. McWhorter M.D.*  
 (Address) *Bourbon Iowa Mo*

Harry Mowbray