

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

Do not use this space.

MAY 31 1937

1. PLACE OF DEATH
102 County Shelby
Township Lentner
City..... (No. St. Ward)

Registration District No. 830
Primary Registration District No. 6095

File No. 17752
Registered No. 23

2. FULL NAME James Washington 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 6 - 1860
7. AGE YEARS 76 MONTHS 7 DAYS 19 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr - 26 - 1937
22. I HEREBY CERTIFY That I attended deceased from Nov. 3, 1936, to Apr 20, 1937
I last saw him alive on 4 - 20, 1937. Death is said

to have occurred on the date stated above, at 5:30 p.m.
The principal cause of death and related causes of importance were as follows:
Uremic poisoning Date of onset 2-3-37

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelby Co. Mo.
13. NAME Pleasant B. Carroll
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.
15. MAIDEN NAME Francis Beard
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maryland
17. INFORMANT (ADDRESS) Mrs. Katie Carroll
Claressa Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Brown Chapel DATE Apr - 27 - 1937
19. UNDERTAKER (ADDRESS) E. P. Morrison
Shelbyville, Mo.
20. FILED April 27 1937 Ruth Joyner
Registrar.

Other contributory causes of importance:
137
Uterus sclerosed
Prostatic hypertrophy
Hypertrophy of prostate gland
Name of operation Prostatectomy Date of 2-1-37
What test confirmed diagnosis? Urinal Was there an autopsy? no.

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) G. M. Hood, M. D.
(Address) Shelbyville 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.

137

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Shelby
Township Leitch
City _____ (No. _____)

Registration District No. 830
Primary Registration District No. 6098

File No. 17752
Registered No. 23

2. FULL NAME

James Washington 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 m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS) _____

20. FILED June 16 1937 Pearl Goe Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 25 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19_____

I last saw him _____ alive on _____, 19_____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset _____

Other contributory causes of importance:

arterio-sclerosis
prostatic obstruction
hypertrophy

Name of operation _____ Date of _____

What test 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? _____

If so, specify _____

(Signed) A. M. Wood, M. D.
(Address) Shelby

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

5-17752