

REC'D OCT 7 1938

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

32859

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 605
 (b) Township Cons Primary Registration District No. 4359 Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Carlisle

(a) Residence, No. _____ St. _____
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 1920 Rachel Carlisle

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-8-1920

7. AGE YEARS 18 MONTHS 7 DAYS 24 If LESS than 1 day,hrs. ormin.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
 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) Mo13. NAME Milo Carlisle14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill15. MAIDEN NAME Stella Uselton16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill17. INFORMANT (ADDRESS) Milo Carlisle
Parma Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Malden DATE Sept 3-3819. FUNERAL DIRECTOR (NAME) (ADDRESS) J. C. King Dr
Parma Mo20. FILED 9-3-38 Dr. Geo W. Husted Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 2 1938

22. I HEREBY CERTIFY, That I attended deceased from Aug 30 1938, to Sept 2 1938
 I last saw him alive on Sept 2 1938. Death is said to have occurred on the date stated above, at 4:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Typhoid Fever Date of onset 8-26-38

Other contributory causes of importance:

Malaria

Name of operation _____ Date of _____
 What test confirmed diagnosis? clinical 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? _____
 If so, specify _____ (Signed) J. A. Bist, M. D.

(Address) Carrollton - Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.