

157 OCT 26 1938

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

33137  
Do not use this space.

1. PLACE OF DEATH

(a) County Wagoner Registration District No. 749  
(b) Township Wagoner Primary Registration District No. 5984 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(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

Albert Frankle Corns 5511  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 25, 1938

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1938, to Aug 25, 1938  
I last saw him alive on Aug 23, 1938. Death is said to have occurred on the date stated above, at 8:30 m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 13, 1912

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

7. AGE YEARS MONTHS DAYS / If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 46 5 6

Date of onset

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W a worker  
9. Industry or business in which work was done, as saw mill, bank, etc. Shoek & Pick  
10. Date deceased last worked at this occupation (month and year) also 11. Total time (years) spent in this occupation carpenter

malignant malaria

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

Other contributory causes of importance: Cerebral hemorrhage

FATHER 13. NAME Carl Gail

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carl Gail

What test confirmed diagnosis? clinical Was there an autopsy? no

MOTHER 15. MAIDEN NAME Carl Gail

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)

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carl Gail

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS) Mrs. E. M. G. G. G.

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Reynolds Cemetery DATE 8/26/38

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) Norman White  
Don Grouton

(Signed) E. M. G. G. G., M. D.  
(Address) Pesterville, Mo.

20. FILED 8/26 1938 Local Registrar 672

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FEB 16 1948

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No. ....  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....  
..... L. E. ....  
No. .... or by ....., Registered Apprentice No. ....  
working under my personal supervision.

Signed .....

Licensed Embalmer No. ....

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

33137  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Reynolds Registration District No. 749  
 (b) Township Leeterville Primary Registration District No. 2984 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (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 Albert Frank Carmelo  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Mar  
 (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 13 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
46 5- 10 1/2

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W.P. a  
 9. Industry or business in which work was done, as saw mill, bank, etc. Workers  
 10. Date deceased last worked at \_\_\_\_\_ (month and year) \_\_\_\_\_ (month and year) \_\_\_\_\_ (month and year) \_\_\_\_\_ (month and year)  
Carpenter occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

FATHER  
 13. NAME Can't give  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "

MOTHER  
 15. MAIDEN NAME "  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "

17. INFORMANT (ADDRESS) Mrs Carmelo Leeterville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Graveside Cem DATE 8/26 1938

19. FUNERAL DIRECTOR (ADDRESS) Norman White & Sons Leeterville Mo

20. FILED 8/26/ 1938 B. M. Fitzpatrick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 25 - 1938

22. I HEREBY CERTIFY, That I attended deceased from Aug 20 to Aug 25, 1938  
 I last saw him alive on Aug 20, 1938. Death is said to have occurred on the date stated above, at 8:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
malignant malaria Date of onset \_\_\_\_\_  
 Other contributory causes of importance:  
Cerebral Hemorrhage  
 Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis clinical 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) C. M. Fitzpatrick, M. D.  
 (Address) Leeterville Mo

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

