

REC'D MAR 16 1939

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

6136
Do not use this space.

1. PLACE OF DEATH

(a) County Carroll 2 Registration District No. 135
 (b) Township 1 Primary Registration District No. 3010 Registered No. 21
 (c) City Carrollton (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

Harriett Caroline Hague
 (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 Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF James E. Hague
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 30 1855
 7. AGE YEARS 80 MONTHS 5 DAYS 10 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
 9. Industry or business in which work was done, as 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) Lynn Co. Mo.

FATHER 13. NAME J. W. Slack
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

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

17. INFORMANT (ADDRESS) Mrs. Ben Guthrie
Carrollton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Goldsberry Mo. DATE Feb 16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stanley
Carrollton Mo.

20. FILED 2-16 1939 uth Hague Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 13 1939
 22. I HEREBY CERTIFY, That I attended deceased from 1-23 1939, to 2-13 1939
 I last saw her alive on 2-12 1939. Death is said to have occurred on the date stated above, at 10:40 m.

The principal cause of death and related causes of importance were as follows:
Chronic Nephritis Date of onset ?
131
 Other contributory causes of importance:
Neural Insufficiency?

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) William G. Atwood, M. D.
130 (Address) Carrollton 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.

RECEIVED
District Health Officer No. 8,
File Number 3/1/89
Filed

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,

Ben W Gibson

, or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Ben W Gibson

Licensed Embalmer No. *2961*

P. O. Address *Carrollton, N*

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.