

REC'D MAR 16 1939

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

6684
Do not use this space.

1. PLACE OF DEATH

(a) County Howard Registration District No. 378
(b) Township Richmond Primary Registration District No. 5-5-26 Registered No. 8
(c) City (d) Street No.
(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

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Carson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12/1st 1939
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
74 2 16

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) Missouri

FATHER 13. NAME Robert Turner
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

MOTHER 15. MAIDEN NAME Adelia Gibson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT Robert Carson, M.
(ADDRESS) Fayette, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Walnut Ridge, DATE 2.21 st 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Guy T. Halley
Fayette, Mo.

20. FILED Mar 5 1939 V. O. Bonham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/9th 1939 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan 30 to 2-19, 1939
I last saw him alive on July 4th 1938. Death is said to have occurred on the date stated above, at 4⁴⁵ P. M.
The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage with left hemiplegia

Date of onset
1933

Other contributory causes of importance:
Fractured left hip! Sept 1935

Name of operation none Date of
What test confirmed diagnosis Physical 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) Wm. J. Shaw, M. D.
Fayette, Mo. (Address)

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.

144 B
1939

RECEIVED
District Health Officer No. 8,
District File Number
2/8/39
Date 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,

....., 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

6684
Do not use this space.

1. PLACE OF DEATH

(a) County Howard Registration District No. 378
 (b) Township Richmond Primary Registration District No. 5526 Registered No. 8
 (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 Mrs Frances Carson

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 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.
74 2 16

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.
 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19 _____

Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 19 - 1939

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

I last saw h. _____ 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:

Cerebral Hemorrhage
left hemiplegia of 6 hr
 Date of onset _____

Other contributory causes of importance
fractured left hip, intra capsular fracture due to fall following hemiplegia.

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) Wm. J. Johnson, M. D.

(Address) Fayette Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

