

REC'D APR 24 1939

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

11423
Do not use this space.

1. PLACE OF DEATH *2*
(a) County *Linn* Registration District No. *496*
(b) Township *Brookfield* Primary Registration District No. *3025* Registered No. *28*
(c) City *Brookfield* (d) Street No. _____ St. _____
(e) Length of residence in city or town where death occurred *49* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.
2. PRINT FULL NAME *Dora Alice Carel*
(a) Residence, No. *516 S. Livingston* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF *William Norman Carel*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec. 16 - 1874*
7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min.
64 3 6
8. Trade, profession, or particular kind of work done, as a sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. *At Home*
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

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

FATHER 13. NAME *James Nickerson* 14. BIRTHPLACE (CITY OR TOWN) *Unknown* (STATE OR COUNTRY) *Missouri*

MOTHER 15. MAIDEN NAME *Elizabeth Golden* 16. BIRTHPLACE (CITY OR TOWN) *Unknown* (STATE OR COUNTRY) *Missouri*

17. INFORMANT *Mrs. Louise Thorne* (ADDRESS) *Brookfield Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Rose Hill Cemetery* DATE *Mar. 24, 1939*

19. FUNERAL DIRECTOR (NAME) *Hill Funeral Chapel* (ADDRESS) *Brookfield Mo.*

20. FILED *Apr 1, 1939* *W. H. Mott* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar - 22*, 19*39*
22. HEREBY CERTIFY, That I attended deceased from *Dec 26*, 19*38*, to *Mar 22*, 19*39*.
I last saw h. *her* alive on *Mar 22*, 19*39* Death is said to have occurred on the date stated above, at *10:30 p* m.
The principal cause of death and related causes of importance were as follows:

Ch. Cardiac Decompensation Date of onset _____
46
Other contributory causes of importance: *Carcinoma of stomach* *Unknown*

Name of operation *None* 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? *No*
If so, specify _____
(Signed) *James W. ...* M. D.
Brookfield 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.

RECEIVED

District Health Officer No. 10

District File Number 10-34-592

Date Filed APR 13 1939

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,

J H Blacklock

....., or by

Registered Apprentice No., working under my personal supervision.

Signed.....

J H Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield Mo

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.