

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.

REC'D JUN 20 1939

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

18286
 Do not use this space.

1. PLACE OF DEATH
 (a) County Carroll Registration District No. 135
 (b) Township Carrollton Primary Registration District No. 3010
 (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Sally Hester Haskins
 (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 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 Robert C. Haskins
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 24, 1862
 7. AGE YEARS 77 MONTHS 0 DAYS 5 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) Carroll Co. Mo
 13. NAME Wm B. Austin
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bedford Co. Virginia
 15. MAIDEN NAME Ruth Bowdry Austin
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky
 17. INFORMANT (ADDRESS) Ruth Haskins
Carrollton Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Hill Cem DATE May 31, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stanley
Carrollton Mo.
 20. FILED 5/31 1939 Robert Haskins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) - May 29, 1939
 22. I HEREBY CERTIFY, That I attended deceased from 5-1 1939 to 5-29 1939
 I last saw her alive on 5-29 1939 Death is said to have occurred on the date stated above, at 1:25 P.M.
 The principal cause of death and related causes of importance were as follows:
Apoplexy
 Date of onset _____
 Other contributory causes of importance: _____
 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) H. B. Senger, M. D.
 (Address) Carrollton Mo

DATE FILED
DISTRICT FILE NUMBER
DISTRICT HEALTH OFFICER NO. 8
RECEIVED

6/8/39

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..... *Ben W Gibson*

Licensed Embalmer No. *2961*

P. O. Address..... *Carrollton, Ga*

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.