

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.

NOV 24 1939

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

Do not use this space.

36024

## 1. PLACE OF DEATH

County *Franklin*Registration District No. *300*

File No. ....

Township *Lyon*Primary Registration District No. *5417*Registered No. *10*

City

(No. ....)

St. ....

Ward) ....

## 2. FULL NAME

(a) Residence, No. ....

St. ....

Ward. ....

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. ....

mos. ....

ds. ....

How long in U. S., if of foreign birth? yrs. ....

mos. ....

ds. ....

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*female*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

## 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

## 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

*Sept. 15, 1939*

## 7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

## OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, 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)

*R.F.D. New Haven Mo.*

## MOTHER

## 13. NAME

*Allen G. Carroll*

## 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

*New Waukegan Mo.*

## 15. MAIDEN NAME

*Mabel B.B. Smith*

## 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

*St. Louis Mo.*

## 17. INFORMANT (ADDRESS)

*Allen G. Carroll New Haven Mo.*

## 18. BURIAL, CREMATION, OR REMOVAL

PLACE *New Haven* DATE *Sept. 16, 1939*

## 19. UNDERTAKER (ADDRESS)

*G. W. Hall*

## 20. FILED

*9/17 1939 G. W. Hall Registrar*

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 15, 1939*22. I HEREBY CERTIFY, That I attended deceased *Sept. 15,* 1939, to .....

I last saw h..... alive on ....., 19..... Death is said

to have occurred on the date stated above, at *11:00 p.m.*

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

*Asphyxia due to Abruptio Placentae*

Date of onset

Other contributory causes of importance:

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?.....

If so, specify

(Signed) *G. W. Hall M.D.*291 (Address) *New Haven, Mo.*

