DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6233

Registration District No. 136 Primary Registration District No. 5204 Registrar's No.

1. PLACE OF DEATH:

(a) County Carroll

(b) ~~City or town~~ Miami TP (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community (Oleviate) years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

(c) City or town Miami TP Rural (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Oleviate B Womack 526

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Oliver L Womack

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 9 (Month) 16 (Day) 1869 (Year)

8. AGE: Years 72 Months 5 Days 13 If less than one day hr. min.

9. Birthplace Carrollton (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation House work

11. Industry or business

FATHER
12. Name William J Boyer
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Adkins
15. Birthplace Carrollton Mo (City, town, or county) 0 (State or foreign country)

16. (a) Informant's own signature Mrs C W Butler

(b) Address Miami Station, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington Cem Kansas City Mo

18. (a) Signature of funeral director

(b) Address Willis-Marshall 131

19. (a) March 2-4° (Date received local registrar) (b) Alta Henderson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 29 year 1940 hour 4:35 am minute M.

21. I hereby certify that I attended the deceased from 2/28, 1940, to 2/29, 1940; that I last saw her alive on 2-29-, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency

Due to

Due to 92 d

Other conditions Senility (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature R Hamilton Slater (M. D. or other)

Address Carrollton Mo Date signed 3/4/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sta[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importan[illegible]

Rev. 5-17-39 I X19511

RECEIVED
District Health Office No. 8
District File Number 3/5-/46
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 Me

, Registered Apprentice No.

working under my personal supervision.

Signed J E Wells

Licensed Embalmer No. 1783

P. O. Address Cameron 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.