

S. No. 2  
-11-10-39  
-5-17-39  
-I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

19568  
State File No. 98

FILED APR 4 1940  
Registration District No. 138

Primary Registration District No. 6203

Registrar's No.

17

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

1. PLACE OF DEATH  
(a) County Carroll, Fair Hill Twp  
(b) City or town Carroll, Mo. R.F.D.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 2-0  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 2 2 0  
years, months or days

3. (a) PRINT FULL NAME Callie Ann Isaacs  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 10 1940  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 12 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Carroll County, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Linn Isaacs  
13. Birthplace Mo. (City, town, or county) (State or foreign country)  
14. Maiden name Hampton  
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Linn Isaacs  
(b) Address Carroll R.F.D. 1

17. (a) \_\_\_\_\_ (b) Date thereof March 23-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Emon

18. (a) Signature of funeral director E. B. Dukerson  
(b) Address Boyard, Mo.

19. (a) 3-22-40 (b) B. C. Colby  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Carroll  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 22  
year 1940 hour 12:30 minute A M.

21. I hereby certify that I attended the deceased from Mar 10  
~~Mar 10~~ 1940 to Mar 22 1940  
that I last saw her alive on 3-22 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature P. Hamilton (City or town) (State) Mo.  
Address Carroll Mo. Date signed Mar 23 1940

Duration 3 da.  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 8,  
District File Number  
4-340  
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 \_\_\_\_\_

working under my personal supervision.

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

Signed E. J. Deussen

Licensed Embalmer No. 2534

P. O. Address Bayard 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.**