APR 23 1940

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

12786
Do not use this space.

1. PLACE OF DEATH
(a) County Worth — Registration District No. 903
(b) Township ~~[illegible]~~ or — Primary Registration District No. ~~[illegible]~~ 4545 — Registered No.
(c) City Grant City, Mo. — (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. ..... ds. (f) How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. PRINT FULL NAME EDWARD CARROLL
(a) Residence, No. ..... St. ..... (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Margaret Carroll
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 1 / 1 / 1860
7. AGE: YEARS 80 — MONTHS 2 — DAYS 28 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Farmer
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: Life

12. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Ohio

FATHER
13. NAME Thomas Carroll
14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Maryland

MOTHER
15. MAIDEN NAME Ann Zulion
16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Maryland

17. INFORMANT Pauline Carroll
(ADDRESS) Grant City, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Grant City, Mo. DATE 3/31 1940

19. FUNERAL DIRECTOR (NAME) Arch C Dunfee
(ADDRESS) Grant City, Mo.

20. FILED Apr. 10, 1940 Clifford Haas Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-28 1940

22. I HEREBY CERTIFY, That I attended deceased from 12-1 1939 to 3-29 1940
I last saw him alive on 3-28 1940. Death is said to have occurred on the date stated above, at 1:10 a.m.
The principal cause of death and related causes of importance were as follows:

Mitral regurgitation of heart — Date of onset: 1937

Other contributory causes of importance:
Influenza — 1940

Name of operation none Date of
What test confirmed diagnosis? Physical findings 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) [illegible] Hoss M.D. M. D.
(Address) Grant City, Mo.

968

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

I X16605

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..... Arch C Dunfee

Licensed Embalmer No..... 3252

P. O. Address Grant City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

. No. 2B
-2-21-40
'22659'

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12786

Registration District No. 903 Primary Registration District No. 4 of 42 Registrar's No.

1. PLACE OF DEATH:
(a) County Worth
(b) City or town Grant city
(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)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME Edward Carroll
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced ma
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 80 Months 2 Days 28 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Apr. 10, 1940 (Date received local registrar) (b) Clifford Haas (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 28
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 E. J. Ross (M. D. or other)
Address Grant City Date signed 3-30

SUPPLEMENTARY

S-12786 1940