

FILED MAY 13 1940

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

14473
Do not use this space.

1. PLACE OF DEATH
 (a) County Calloway Registration District No. 104
 (b) Township 3 Primary Registration District No. 3008 Registered No. 122
 (c) City Julton (d) Street No. State Hospital #1 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. 25 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Frank A McCarvel
 (a) Residence, No. State Hospital No 7 St. Chariton County
 (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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF DK

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 3 1866

7. AGE YEARS	MONTHS	DAYS	IF LESS THAN 1 day, hrs. or min.
<u>73</u>	<u>11</u>	<u>27</u>	

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lafayette County, Mo

FATHER

13. NAME Francis McCarvel

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland 5

MOTHER

15. MAIDEN NAME Margaret Sweeney

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa. 1

17. INFORMANT (ADDRESS) County Clerk, Keokusville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Salisbury Mo DATE 4-2 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jack B. Wilhelmeyer, Salisbury Mo

20. FILED May 1, 1940 R. N. Dewar Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-30 1940

22. I HEREBY CERTIFY, That I attended deceased from April 1 1940 to April 30 1940
 I last saw him alive on April 30 40 Death is said to have occurred on the date stated above, at 10:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Generalized arterio sclerosis
with Hypertension
 Date of onset

Other contributory causes of importance:
Infection in leg arm
Dehydration
 4-25-40

Name of operation..... Date of.....
 What test confirmed diagnosis? Clin. Hist. Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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) Jessie Thomas M. D.
 (Address) State Hospital no 1, Julton

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.

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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.....

Licensed Embalmer No.....

P. O. Address.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14473**

Registration District No. **104**

Primary Registration District No. **32008**

Registrar's No. **122**

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

1. PLACE OF DEATH

(a) County **Callaway**
(b) City or town **Julton**
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Frank A. McCarvel

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 **m**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **73** Months **11** Days **27** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 **4** day **30** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that I last saw him _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized arteriosclerosis with hypertension** Duration _____

Due to _____

Due to _____

Other condition **Infection in left arm - Dehydration** (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) **Accident**

(b) Date of occurrence **4-22-40**

(c) Where did injury occur? **Julton Callaway Mo.** (City or town) (County) (State)

(d) Did injury occur in, or about home, on farm, in industrial place, in public place? **State Hospital #1**

While at work? **No** (Specify type of place) (e) Means of injury **Fall**

23. Signature **Frederick Thomas** (M. D. or other) _____

Address **Julton Mo** Date signed _____

State Hosp #1

SUPPLEMENTAL COPY

S-14473