

FILED MAY 2 1940  
Registration District No. \_\_\_\_\_

790 Primary Registration District No. 4479

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: *Saline*

(a) County: *Saline*

(b) City or town: *Slater Mo*  
(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: *35 years* (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: *Mo* (b) County: *Saline*

(c) City or town: *Slater*  
(If outside city or town limits, write "RURAL")

(d) Street No.: *918 Grandview*  
(If rural, give location)

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

3. (a) PRINT FULL NAME: *Malinda May Carr*

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No.: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* day *20*  
year *1940* hour *4* minute *40 P.* M.

21. I hereby certify that I attended the deceased from *Jan 9 - 40*  
\_\_\_\_\_ 19*40*, to *April 20*, 19*40*  
that I last saw her alive on *April 20*, 19*40*  
and that death occurred on the date and hour stated above.

4. Sex: *Female*

5. Color or race: *White*

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

6. (b) Name of husband or wife: *C P Carr*

6. (c) Age of husband or wife if alive: *77* years

7. Birth date of deceased: *October 22 1868*  
(Month) (Day) (Year)

Immediate cause of death: *Carcinoma of Colon*

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death): *46*

8. AGE: Years *71* Months *5* Days *28* If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace: *Clark Co Indiana*  
(City, town, or county) (State or foreign country)

10. Usual occupation: *House wife*

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

12. Name: *William Carr*

13. Birthplace: *Clark Co Indiana*  
(City, town, or county) (State or foreign country)

14. Maiden name: *Margaret Summers*

15. Birthplace: *Clark Co Indiana*  
(City, town, or county) (State or foreign country)

16. (a) Informant: *C S Carr*

(b) Address: *Slater Mo*

17. (a) *Burial* (b) Date thereof: *4-23-40*  
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial: *Slater City*

18. (a) Signature of funeral director: *W. M. Smith*

(b) Address: *Slater Mo*

19. (a) *4-22* (b) *W. M. Smith*  
(Date received local registrar) (Registrar's signature)

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: *E. W. Caldwell* (M. D. or other) \_\_\_\_\_

Address: *Slater Mo* Date signed: *4-22-40*

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

**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. *214*

P. O. Address *Slater, 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.