

15-10-39
5-17-39
I X21492

Registration District No. 875

Primary Registration District No. 6167

State File No. _____

Registrar's No. 117

1. PLACE OF DEATH:
 (a) County Vernon
 (b) City or town RUNAWAY-WASHINGTON
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
State Hospital No 3.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 14yrs 8mo 21days
(Specify whether)
 In this community _____
 years, months or days 5

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Greene
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 2405 N. Broadway
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME MARTHA V. CARR
 (b) If veteran, name war _____ (c) Social Security No. Not known

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 16th
 year 1940 hour 1:00 minute P. M.
 21. I hereby certify that I attended the deceased from August 24th
1939 to April 16th, 1940
 that I last saw her alive on April 16th, 1940
 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 Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased August 26th 1908
(Month) (Day) (Year)

Immediate cause of death Pulmonary Tuberculosis
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations no operation
 Of autopsy Bilateral pulmonary tuberculosis, Ulcerative Colitis, or Peritonitis

8. AGE: Years Months Days If less than one day
31 7 21 _____ hr. _____ min.
 9. Birthplace GERADO OHIO
(City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

10. Usual occupation Student
 11. Industry or business _____
 12. Name Joseph B. Carr
 13. Birthplace Newarkville Ohio
(City, town, or county) (State or foreign country)
 14. Maiden name E. Mabel Hoyle
 15. Birthplace Crawford Kansas
(City, town, or county) (State or foreign country)

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?
795
(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature G. S. Waraich (M. D. or other) _____
 Address State Hospital Nevada Date signed 4/16/40

16. (a) Informant State Hospital Records
 (b) Address Nevada, Mo
 17. (a) Burial (b) Date thereof 4/18/40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Joseph Cemetery
 18. (a) Signature of funeral director Hayes Funeral Home
 (b) Address Nevada, Mo
 19. (a) 4/17/40 (b) Allen V. Hayes
(By or through local registrar) (Registrar's signature)

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

18

RECEIVED
District Health Officer No. 7,
District File Number 5-40-734
Date Filed 5-6-40

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 Allen V. Hays

Licensed Embalmer No. 1988

P. O. Address Nevada, 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.