

MAILED JUN 17 1940

Registration District No. 397 Primary Registration District No. 4534 Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Greenwood mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home in town 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 20 years, months or days

**8. (a) PRINT FULL NAME** Carl Mead 304

8. (b) If veteran, name war no

8. (c) Social Security No. 476-09-8534

4. Sex m 5. Color or race W

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

6. (b) Name of husband or wife Haller mead

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

7. Birth date of deceased march 21 1883  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>57</u>	<u>1</u>	<u>15</u>	hr. _____ min. _____

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

10. Usual occupation Labourer

11. Industry or business Gen.

**MOTHER FATHER**

12. Name Carroll E mead

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

14. Maiden name Susan E. mead

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

16. (a) Informant Mr. Haller mead

(b) Address Greenwood mo

17. (a) Burial (b) Date thereof 5-8-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director W. G. Langford

(b) Address Lee's Summit mo.

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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

(c) City or town Greenwood mo  
(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 May day 6  
year 1940 hour 7 6 minute 25 P.M.

21. I hereby certify that I attended the deceased from 4-24 1940 to 5-6 1940  
that I last saw him alive on 3-1 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis

Duration ?

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

Due to 92%

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings:  
Of operations \_\_\_\_\_

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

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? 359

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

23. Signature [Signature] (M. D. or other) 1700

Address Lee's Summit Date signed 5/7/40

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

No. 39  
39  
X21492

**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 \_\_\_\_\_

*N. B. Langford*

Licensed Embalmer No. \_\_\_\_\_

*3833*

P. O. Address \_\_\_\_\_

*Lee's Summit, 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.**

DC

No. 2B  
2-21-40  
I X22659

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 18614

Registration District No. 397

Primary Registration District No. 4234

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

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Greenwood  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Carl meal

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 \_\_\_\_\_ years

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

8. AGE: Years 57 Months 1 Days 15 If less than one day, hr. min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

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 (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 5-8-1940 (b) Mrs. Lallie G. Hayes  
(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 May day 6  
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 \_\_\_\_\_

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

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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

Duration

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?

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

23. Signature L.P. Wright (M. D. or other) \_\_\_\_\_

Address Lee Summit Date signed \_\_\_\_\_  
mo.

SUPPLEMENTAL

