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FILED OCT 18 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **81977**

Registration District **00302**

Primary Registration District No. **4181**

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

1. PLACE OF DEATH: **GASCONADE**

(a) County **GASCONADE**

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

(c) Name of hospital or institution: **BLAND MO.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **20**  
(Specify whether years, months or days)

In this community **82 YRS.**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **GASCONADE**

(c) City or town **BLAND**  
(If outside city or town limit, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

3. (a) PRINT FULL NAME **SUSAN EMILY CARWILE**

3. (b) If veteran, name war \_\_\_\_\_  (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **SEPT.** day **15**  
year **1940** hour **5** minute **0** M.

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife **W.M. CARWILE** 6. (c) Age of husband or wife if alive **DEAD** years

7. Birth date of deceased **AUG. 25 1858**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 10**, 1940, to **Sept 15**, 1940  
that I last saw her alive on **Sept 14**, 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years **82** Months **0** Days **20** If less than one day  
hr. min.

Immediate cause of death **Endocarditis**  
Duration

9. Birthplace **MILLER COUNTY MO.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WORK**

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

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

Other conditions **978**  
(Include pregnancy within 3 months of death)

11. Industry or business **9**

12. Name **GILBERT PLITMAN**

13. Birthplace **NOT KNOWN**  
(City, town, or county) (State or foreign country)

14. Maiden name **NOT KNOWN**

15. Birthplace **NOT KNOWN**  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

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

Of autopsy **720**

Underline the cause to which death should be charged statistically.

16. (a) Informant **FRED BRANSON**  
(b) Address **GERALD MO.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) **BURIAL** (b) Date thereof **SEPT. 17 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **COLLEGE HILL CEM.**

(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? **277**

18. (a) Signature of funeral director **W. F. Gattenstrater**  
(b) Address **Owensville Mo.**

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

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

23. Signature **C. A. Bunge** (M. D. \_\_\_\_\_)  
Address **Bland Mo** Date signed **Sept 14 40**

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

MOTHER FATHER

**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 Me

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Milford H. H. Winter

Licensed Embalmer No. 3838

P. O. Address Queneville 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31977

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 307

Primary Registration District No. 4181

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

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

1. PLACE OF DEATH:

(a) County Gasconade  
(b) City or town Bland  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME

Susan Emily Carville

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

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

4. Sex F 5. Color or race w

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

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 Months Days If less than one day min.  
82 0 20 \_\_\_\_\_ 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. (Month) (Day) (Year)

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

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

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

19. (a) Sep 15-40 (b) C. A. Bunge, M.D. (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.

20. DATE OF DEATH: Month Sept day 15 year \_\_\_\_\_ 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.

Immediate cause of death \_\_\_\_\_

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

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

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

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

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

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 C. A. Bunge (M. D. or other) \_\_\_\_\_

Address Bland Mo Date signed \_\_\_\_\_

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

