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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 10 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38391

Registration District No. 135 Primary Registration District No. 3010 Registrar's No. 107

1. PLACE OF DEATH:

(a) County Carroll

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

(c) Name of hospital or institution: South Side Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 weeks (Specify whether In this community years, months or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

(c) City or town Carrollton (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

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

3. (a) PRINT FULL NAME John F. Cary

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 Widowed

6. (b) Name of ~~husband or~~ wife Avos Cary

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

7. Birth date of deceased 1 (Month) 16 (Day) 1874 (Year)

8. AGE: Years 66 Months 10 Days 14 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name William Cary
13. Birthplace Carroll Co (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Nancy Baker
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Luther Cary

(b) Address Carrollton Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (Month) 3 (Day) 1940 (Year)

(c) Place: burial or cremation Gilead Cemetery

18. (a) Signature of funeral director Willis-Marshall

(b) Address Carrollton Mo

19. (a) 12-3-1940 (Date received local registrar) (b) Ruth Haskins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 30 year 1940 hour 11:30 minute a M.

21. I hereby certify that I attended the deceased from Oct 20 to , 19 , to Nov 30 , 1940; that I last saw him alive on Nov 30 , 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma Prostate	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy no	

51

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? (Specify type of place)

130

While at work? (e) Means of injury

23. Signature [signature] (M. D. ~~or other~~) 1

Address [illegible] Date signed 12-3-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12-24-40

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

Signed P. M. Marshall

Licensed Embalmer No. 2535

P. O. Address Carrollton 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.