S. No.
-11-...
5-17-39
I X21492

FILED FEB 14 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1919

Registration District No. 89 Primary Registration District No. 3007 Registrar's No. 12

12
7
3

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

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Poplar Bluff (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Poplar Bluff Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Week (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler 12 7 3
(c) City or town Poplar Bluff (If outside city or town limits write "RURAL")
(d) Street No. 1102 Tremont (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Maude Carpenter
3. (b) If veteran, name war ..... 3. (c) Social Security No. .....
4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Earnest 6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased April (Month) 6 (Day) 1901 (Year)

8. AGE: Years 39 Months 9 Days 5 If less than one day ..... hr. ..... min.

9. Birthplace Bloomfield (City, town, or county) Mo (State or foreign country)
10. Usual occupation at Home
11. Industry or business .....
FATHER 12. Name unknown
13. Birthplace unknown (City, town, or county) 9 (State or foreign country)
MOTHER 14. Maiden name unknown
15. Birthplace unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant Earnest Carpenter
(b) Address 1102 Tremont st
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 12-41 (Month) (Day) (Year)
(c) Place: burial or cremation Dexter Mo
18. (a) Signature of funeral director Frank Mortuary
(b) Address Poplar Bluff Mo
19. (a) 1/12/41 (Date received local registrar) (b) Kate Lutz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11 year 1941 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec -, 1940, to Jan 11, 1941; that I last saw her alive on Jan 10, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Bacterial endocarditis and Myocarditis -	6 days
Due to: Septicemia - following Phlebitis & Rt leg	4 mo
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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)
While at work? ..... (e) Means of injury .....

23. Signature A. Brookman (M. D. or other) M.D.
Address Poplar Bluff Mo Date signed 1-12-41

(Licensed Embalmer's Statement on Reverse Side)

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 Grover W. Green

Licensed Embalmer No. 2964

P. O. Address Poplar Bluff M

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.

S. No. 2B
—7-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1919

Registration District No. 89 Primary Registration District No. 3007 Registrar's No. 12

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Poplar Bluff (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 years, months or days)

In this community

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.

3. (a) PRINT FULL NAME Maud Carpenter

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 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 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 11 year 1941 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 Acute Bacterial Endocarditis and Myocarditis Chr.

Due to Phlebitis

Due to Cause Unknown (no pneumonia)

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 93 F

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature A. F. Brookreson MD (M. D. or other)

Address Poplar Bluff Mo Date signed 4-12-41

A.F. BROOKRESON

A.F. BROOKRESON