

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 1104

Primary Registration District No. 5415

Registrar's No. 1

36
 00

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

1. PLACE OF DEATH:
 (a) County Franklin
 (b) City or town Sullivan
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Rural, Boon Twn. Mo.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)
 In this community All his life

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri, (b) County Franklin
 (c) City or town Sullivan
(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 Michael Carey
 (b) If veteran, name war No
 (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 29th.
 year 1941 hour 3 minute P. M.

4. Sex Male
 5. Color or face White
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Laura Carey
 (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 26th. 1872
(Month) (Day) (Year)

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.

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>10</u>	<u>3</u>	hr. _____ min.

Immediate cause of death Cerebral
of throat & chest type
 Due to unknown cause

9. Birthplace Jefferson County, Missouri
(City, town, or county) (State or foreign country)
 10. Usual occupation Farmer

Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____
 12. Name Michael Carey
 13. Birthplace Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Mason
 15. Birthplace Ireland
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant E. M. Carey
 (b) Address Sullivan, Mo. R.F.D. #2
 17. (a) Burial (b) Date thereof Feb. 1, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Catholic Cem. Sullivan Mo.

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? _____

18. (a) Signature of funeral director J. S. Miller
 (b) Address Sullivan, Mo.
 19. (a) Feb. 8 - 41 (b) Charles A. Schmitt
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) _____
 Address Sullivan, Mo. Date signed _____

4.5

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

J. J. Williams

Licensed Embalmer No. 427

P. O. Address Sullivan, 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. 25-22

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1104

Primary Registration District No. 5415

Registrar's No. _____

R

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Boone, Mo.
(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 Michael Carey

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 _____ year

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

8. AGE: Years 68 Months 10 Days 3 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 _____ (City, town, or county) _____ (State or foreign country)

{ 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) _____ (b) _____
(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.

20. DATE OF DEATH: Month Jan day 29 year _____ 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 Primary throat metastasizing to chest

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

458

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 R. P. Ryan (M. D. or other) _____
Address Sullivan, Mo. Date signed _____

SUPPLEMENTARY

Physician _____

Underline the cause to which death should be charged statistically.

