

DEPARTMENT OF COMMERCE **RECEIVED MAY 20 1941** MISSOURI STATE BOARD OF HEALTH
 BUREAU OF THE CENSUS **STANDARD CERTIFICATE OF DEATH**

16098

State File No. _____

Registration District No. 849

Primary Registration District No. 6114A

Registrar's No. 41

1. PLACE OF DEATH:
 (a) County Sullivan
 (b) City or town Penn Township
 (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 Life
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Sullivan ¹⁰⁵
 (c) City or town Rural (If outside city or town limits, write "RURAL") ⁰
 (d) Street No. _____ (If rural, give location) ⁰
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Maude Belle Carrol
 (b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 19
 year 1941 hour 5:00 minute 0 M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Don Carrol
 (c) Age of husband or wife if alive 10 years
 7. Birth date of deceased January 10 1881
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 28
 1940 to April 19 1941
 that I last saw her alive on April 19 1941
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>3</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death CARCINOMA OF UTERUS
OF STOMACH
 Due to _____
 Due to _____

9. Birthplace Glenwood Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

MOTHER FATHER
 12. Name John Riley
 13. Birthplace Johnson Co. Ohio
 (City, town, or county) (State or foreign country)
 14. Maiden name Nancy Jane Thompson
 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Glen Riley
 (b) Address Stahl, Mo.
 17. (a) Burial (b) Date thereof April 21, 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

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)

(c) Place: burial or cremation Green Castle
 18. (a) Signature of funeral director Glen E. Tentz Sr.
 (b) Address Green City, Mo.
 19. (a) May 1-1941 (b) Virginia Giben
 (Date received local registrar) (Registrar's signature)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
701 (Specify type of place) 2
 (e) Means of injury _____
 23. Signature V. E. Schurr (M. D. or other) 10
 Address Green City, Mo. Date signed 4-19-41

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

46

RECEIVED

District Health Officer No. 10

District File Number 5-41-935

Date Filed MAY 14 1941

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 Archie W Wade

Licensed Embalmer No. 3037

P. O. Address Green City

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16098

Registration District No. 849

Primary Registration District No. 6114 A

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Penn 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 _____
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Maudie Belle Carroll

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 W

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 60 Months 3 Days 9 If less than one day _____ 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) _____ (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) Citizen of foreign country _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 19
year 1947 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. Carcinoma of Stomach Diagnosis

Due to Carcinoma of uterus

Due to Primary seat of Metastases - Stomach

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? _____

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

23. Signature F. E. Schurr (M. D. or other) _____

Address New City, Mo. Date signed _____

SUPPLEMENTAL

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

MOTHER FATHER

