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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILLED OCT 15 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31289

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. 97

1. PLACE OF DEATH:  
(a) County Cassell  
(b) City or town Carrollton 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 40 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Cassell 17  
(c) City or town Carrollton Mo (If outside city or town limits, write "RURAL")  
(d) Street No. 601 west 6th (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Henry Cave  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 9 day 12th  
year 1941 hour 7 minute 0 P.M.  
21. I hereby certify that I attended the deceased from Jan 1 to Sept 12 1941  
that I last saw him alive on Sept 12 1941  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Sarah Ann Hamilton Cave 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: (Month) 3 (Day) 9 (Year) 1869

Immediate cause of death arterial emphysema Duration 3 yrs.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 72 Months 6 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Wakarusa Mo (City, town, or county) (State or foreign country)  
10. Usual occupation Retired Farmer

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

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Henry Cave  
13. Birthplace Kennett Mo (City, town, or county) (State or foreign country)  
14. Maiden name Eliabeth Julian  
15. Birthplace Stem (City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant Mrs John Cave  
(b) Address 601 W 6th St Carrollton Mo  
17. (a) Burial (b) Date thereof 9-14-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Walnut Grove  
18. (a) Signature of funeral director Walter Marshall  
(b) Address Carrollton Mo  
19. (a) 9-13-41 (b) John Haskins  
(Date received local registrar) (Registrar's signature)

23. Signature Dr Hamilton Date Sept 14  
Address Carrollton Mo Date Sept 14

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
District Health Officer No. 8,  
District File Number 10-14-41  
Date Filed

**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. ~~326~~  
working under my personal supervision.

Signed J. B. Willis

Licensed Embalmer No. 3861

P. O. Address Carleton, N.C.

**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.**

STANDARD CERTIFICATE OF DEATH

State File No. 31289

Registration District No. 135

Primary Registration District No. 3010

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

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:  
  
(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)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME

John Henry Cave

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

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 3-9-1869  
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 21 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) 9-15-41 (b) Ruth Hoskins  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
\_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ live 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 \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY 12

S-31289 1941