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14186

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED MAY 23 1942

Registration District No. 239

Primary Registration District No. De Motte 5362

Registrar's No. 15

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

1. PLACE OF DEATH:

(a) County De Kalb

(b) City or town Rural Colfax  
(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 no  
(Specify whether years, months or days)

In this community since birth

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clinton

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

(d) Street No. 215 S Walnut  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Carole Kay Livingstone

3. (b) If veteran, name war: ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19  
year 1942 hour 3:00 minute 45 P. M.

21. I hereby certify that I attended the deceased from April 19, 1942, to April 19, 1942, that I last saw her alive on April 19, 1942, and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced ✓

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive 18 years (Day) (Year)

7. Birth date of deceased March 18 1940  
(Month) (Day) (Year)

Immediate cause of death  
accidental (cr. ran over) by automobile

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>2</u>	<u>1</u>	<u>1</u>	_____ hr. _____ min.

22. If death was due to external causes, fill in the following: ✓

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence 0.32

(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 \_\_\_\_\_

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Wm Guy Livingstone

13. Birthplace Plattsburgh Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Ruby Clara Olson

15. Birthplace Osburn Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm Guy Livingstone

(b) Address Cameron Mo.

17. (a) Burial (b) Date thereof Apr 20 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osburn Mo.

18. (a) Signature of funeral director Poland Funeral Home

(b) Address Cameron Mo.

19. (a) 4-21-42 (b) W M Dingle  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

23. Signature Dr. M. S. Gale (M. D. or other)

Address Osburn Mo Date signed 4/19/42

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**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 Herald T. Wade

Licensed Embalmer No. 4172

P.O. Address Cameron Ms

**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. 14186

Registration District No. 259

Primary Registration District No. 5362

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....  
(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 Carole K Livingstone

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

4. Sex. 7 5. Color or race w. 6. (a) Single, widowed, married, divorced 8

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

7. Birth date of deceased mar 18 1948  
(Month) (Day) (Year)

8. AGE: Years 2 Months 1 Days 6 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry of business.....

12. Name..... 1706-6

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)..... (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 1942 hour..... minute..... M.

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

Immediate cause of death.....  
Accidental run over by automobile owned by one of relatives - back wheel of car struck her down and passed over her head and hip crushing her skull. She survived a few moments before a child. Otherwise was a very strong healthy girl.

Other conditions.....  
(If present more than one month before or within a child.)

Manner of death.....  
Operations.....

Of autopsy.....

Duration.....

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) accident

(b) Date of occurrence April 19-1942

(c) Year of injury occurred at home in Oakdale, Mo. (County) (State)

(d) Did injury occur in or about home, or farm, in industrial place, in public place?

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature M. S. Gale M.D. (M. D. or other)  
Address Osborn Mo. Date signed 7/2/42

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

SUPPLEMENTARY

