

No. 2
-1- 41
3390

Registration District No. FILED JUN 15 1942

Primary Registration District No. 3010

Registrar's No. 76

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: South Side Hospital. *D*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community 12 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll. *17*

(c) City or town Dewitt Mo. *0*
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ *D*
(Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 15th day 15th
year 1942 hour 5 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from May 12
_____, 19____, to May 15 19____;
that I last saw her alive on May 15 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Central Embalmers

Due to falling fracture of neck of right femur

Due to _____

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

3. (a) PRINT FULL NAME Ada D. Owings.

3. (b) If veteran, name war XXXX

3. (c) Social Security No. XXXX

4. Sex Female 5. Color or race White

6. (a) Name of husband or wife Woodson Owings 6. (b) Age of husband or wife if alive deceased years _____

7. Birth date of deceased Feb. 4th 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

73 3 II _____ hr. _____ min.

9. Birthplace Adrain County. *D*
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business _____

12. Name John Garretson.

13. Birthplace W. Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Jenkins

15. Birthplace Pike County 0 Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant John Garretson.

(b) Address Dewitt Mo.

17. (a) Burial (b) Date thereof May 17 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo. ~~W. Va.~~

18. (a) Signature of funeral director Willis * Marshall

(b) Address Carrollton Mo.

19. (a) 5-16-42 (b) Mrs. James Rafferty
(Date received local registrar) (Registrar's signature)

Major findings: _____

Of operations _____

Of autopsy _____

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 A. M. Beecher (M. D. or other) *0*

Address Carrollton Mo. Date signed 5/16/42

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

MOTHER FATHER

1053

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed

6-12-42

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. _____

working under my personal supervision.

Signed

R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Connecticut 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17687

Registration District No. 133

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

Ada D. Owings

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 _____ years

7. Birth date of deceased Feb. 4 1869
(Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days _____ If less than one day _____ 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 _____
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month May Day 12 year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I have a law _____ live on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Fracture of Neck of right femur.
Due to a fall down the steps of the County Court House

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

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence May 12-42
(c) Where did injury occur? Carrollton Carroll Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Fell down Courthouse Steps
While at work? No (Specify type of place) (e) Means of injury _____

23. Signature J. W. Williams (M. D. or other) Address Carrollton Mo Date signed 5/14/42

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

