

Registration District No. 23

Primary Registration District No. 3010

Registrar's No. 281

16
1
4

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

1. PLACE OF DEATH:

(a) County New Madrid Cape Girardeau

(b) City or town St. Francis Hos. Cape Gir.

(c) Name of hospital or institution: St Francis Hospital

(d) Length of stay: In hospital or institution about 10 min.
three years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid 72

(c) City or town Matthews Mo

(d) Street No. R.F.D.#

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME Dona Carroll

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

3. (c) Social Security No. _____

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Homer Carroll

6. (c) Age of husband or wife if alive 14 years (Month) (Day) (Year)

7. Birth date of deceased Nov. 14 1900

8. AGE: Years 38 Months I Days 25 If less than one day hr. min.

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

10. Usual occupation farmer Housewife

11. Industry or business _____

12. Name Julius Oliger

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

14. Maiden name unknown

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

16. (a) Informant Husband

(b) Address Matthews, Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Sept. 21, 1942 (Month) (Day) (Year)

(c) Place: burial or cremation Grandview arkansas

18. (a) Signature of funeral director Orville Taylor

(b) Address Sikeston Mo.

19. (a) 10-3-42 (Date received local registrar)

(b) J. H. Phelps (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 20 year 1942 hour 7 minutes 00 A.M.

21. I hereby certify that I attended the deceased from Sept 20 1942 that I last saw her alive on Sept 20 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Post Partum Hemorrhage Duration _____

Due to Childbirth

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 146 e

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 1

23. Signature J. M. Jarvis, M.D. (M. D. or other)

Address Rockham, Mo. Date signed 9/22/42

RECEIVED

District Health Officer No. 4

District File Number 104 2-4283

Date Filed 10-13-42

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.....

....., Registered Apprentice No.....

working under my personal supervision:

Signed *M. C. Boy*.....

Licensed Embalmer No. *3474*.....

P. O. Address *Poplar Bluff*.....

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.