

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 1 1943

Registration District No. 33

Primary Registration District No. 3011

Registrar's No. 2721

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:
Staton Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days
(Specify whether years, months or days)

In this community 72 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll

(c) City or town (Rural)
(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 MARGUERITE HANEY

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2
year 1943 hour 12 minute 10 A.M.

4. Sex Fe. 5. Color or race W.

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

6. (b) Name of husband or wife B.A. Haney

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased July 25 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 6 to Mar. 2 1943
that I last saw her alive on Jan. 2 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Tremor
poison

Duration low

8. AGE: Years 72 Months 7 Days 5
If less than one day _____ hr. _____ min.

Due to Insufficient age

Due to _____

Other conditions (Include pregnancy within 3 months of death)

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

10. Usual occupation At home

11. Industry or business _____

12. Name Henry Diecks

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

14. Maiden name Catherine Stern

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

16. (a) Informant Mrs. Henry Boelsen

(b) Address Carrollton, Mo.

17. (a) Burial (b) Date thereof 3--4--43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cem

18. (a) Signature of funeral director Standley

(b) Address Carrollton, Mo.

19. (a) 3-4-1943 (b) Mrs. James Rafferty
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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? _____

23. Signature B. Hamilton
Address Carrollton, Mo. Date signed 3-3-43

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

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

17-39
X32873

MOTHER FATHER

11) 5 5

403

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

4-6-43

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.....

Ben W. Gibson

Licensed Embalmer No. *2961*

P. O. Address.....

Carrollton 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. 9888
Registrar's No. 27

Registration District No. 21

Primary Registration District No. 3011

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 _____ (Specify whether)

years, months or days

3. (a) PRINT FULL NAME Marguerite Lancy

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 m

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

7. Birth date of deceased July 25
(Month) (Day) (Year)

8. AGE: Years 72 Months 7 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Carroll Mo
(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 _____
(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 March Day 2 Year 1943 hour _____ minute _____ M.

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

Immediate cause of death removal of acute tonsils following teeth extraction
Infantile of age

Due to _____

Due to _____

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

Major findings: Of operations _____ 115a

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

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

