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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15096

FILED MAY 7 1943

Registration District No. 276 Primary Registration District No. 5945 4413 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town St. James Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Matlock Nursing Home 4
(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 Missouri (b) County Phelps

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Edward L. Carson,

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Wh.

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

6. (b) Name of husband or wife

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

7. Birth date of deceased June 20, 1869 (Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 24 If less than one day hr. min.

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

10. Usual occupation House Painter

11. Industry or business

FATHER
12. Name L. Carson,
13. Birthplace Don't Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Kidd
15. Birthplace Scotland (City, town, or county) (State or foreign country)

16. (a) Informant Vernon Carson,
(b) Address Rolla Mo.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Rhea Cemetery

18. (a) Signature of funeral director Null & Son Funeral Home
(b) Address 508 West 8th St., Rolla Mo

19. (a) 4-15-43 (Date received local registrar) (b) Francis Dickson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14 year 1943 hour 3 minute AM M.

21. I hereby certify that I attended the deceased from 4-1-43, 1943, to 4-14-, 1943; that I last saw him alive on 4-2, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Nephritis	
Due to	
Due to	
Other conditions: Myocarditis (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy: None	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address St. James Mo Date signed 4-15-43

1091

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 3397

P. O. Address Rolla 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.

V. S. No. 2B
0M—8-21-41
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15096

Registration District No. 276 Primary Registration District No. 4410 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town St James
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mallack Nurs Home
(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 Edward L Carson

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 ..... (Month) ..... (Day) ..... (Year)

8. AGE: Years 73 Months 9 Days 24 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 14
year 1943 hour ..... minute ..... M.

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

Immediate cause of death ..... Nephritis Chronic

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.

131 L

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature C H Fullington (M. D. or other) .....

Address C H Fullington Date signed .....

S-15096