No. 2
4-13-40
5-17-39
X23155

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 3 1943

Registration District No. _____

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

2000

Primary Registration District No. _____

17831

State File No. _____

Registrar's No. 368

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

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: Springfield Baptist Hospital 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 hrs. (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 34

(a) State Mo. (b) County Douglas

(c) City or town Cross Roads "Rural (If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME Allen Glenn Carson

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M

5. Color or race wht

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased Oct. (Month) 13 (Day) 1926 (Year)

8. AGE: Years ✓ 16 Months 6 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Cross Roads (City, town, or county) Mo 1 (State or foreign country)

10. Usual occupation Home

11. Industry or business

MOTHER FATHER

12. Name Albert William Carson

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

14. Maiden name Eugenia Jane Tatt

15. Birthplace Cross Roads (City, town, or county) Mo 1 (State or foreign country)

16. (a) Informant Mrs Eugenia J. Carson

(b) Address Cross Roads Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-6-43 (Month) (Day) (Year)

(c) Place: burial or cremation Cross Roads Mo.

18. (a) Signature of funeral director CHINKINGBEARD FUNERAL HOME

(b) Address AVA MO

19. (a) 5-10-43 (Date received local registrar) (b) F W Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6 year 1943 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from 5-6-43, 19..., to 5-6, 19 43 that I last saw him alive on 5-6, 19 43 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congestion Heart Failure	2 hrs
Due to: Rheumatic Aortic Insufficiency	2 years
Due to: Rheumatic fever	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 E. E. Allen (M. D. or other)

Address Springfield Mo. Date signed 5/10/43

(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 W. B. Hutchson

Licensed Embalmer No. 3431

P. O. Address Aurora

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.