

FILED SEP 9 1943

Registration District No. 120

Primary Registration District No. 5448

5445

Registrar's No. 79

1. PLACE OF DEATH:

(a) County Gentry  
(b) City or town Albany Rural Huggins Township  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community lifetime (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry  
(c) City or town Gentry Rural Huggins T. Bof. J  
(d) Street No.....  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME

Carylon Kay McMichael

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 Single

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

7. Birth date of deceased August 7 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 4 ..hr. ....min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name Frank McMichael  
13. Birthplace Gentry Missouri  
14. Maiden name Ester Kirshner  
15. Birthplace Unknown N.D.  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank McMichael Missouri  
(b) Address Gentry

17. (a) Burial (b) Date thereof Aug. 11-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenridge

18. (a) Signature of funeral director Robert E. Brooks  
(b) Address Albany, Missouri

19. (a) 8/28/43 (b) Home 227th St  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11  
year 1943 hour 5 minute 45 M.

21. I hereby certify that I attended the deceased from Aug 7  
19 43 to Aug 19 43

that I last saw her alive on Aug 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death Malformation of spinal column that way at birth

Due to .....

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).....  
(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 Charles N. Williamson (M. D. or other) MD  
Address Gentry, Mo Date signed 8-21-43

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

MOTHER FATHER

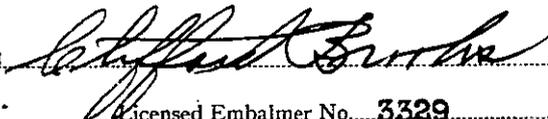
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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**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 me  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed   
.....  
Licensed Embalmer No. 3329.....

P. O. Address Albany, 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.**