

1-4-41
6-17-39
X28390

FILED OCT 13 1943
Registration District No. 147

Primary Registration District No. 1000

Registrar's No. 1060

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 days
(Specify whether years, months or days)

In this community 20 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Taylor

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

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ANNA DORCYLE CARROLL

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 Married

6. (b) Name of husband or wife Ray Carroll 6. (c) Age of husband or wife if alive 37 years

7. Birth/date of deceased Aug. 13 1905
(Month) (Day) (Year)

8. AGE: Years 35 Months 1 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Edward Armstrong

13. Birthplace My. Agr. Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Eva Hellingmuth

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

16. (a) Informant Ray Carroll

(b) Address Blackston, Iowa

17. (a) Burial (b) Date thereof 9-30-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Traylor cemetery

18. (a) Signature of funeral director J. C. Duffler

(b) Address Grant city, Mo.

19. (a) 9/30/43 (b) W. Ryan
(Date received local registrar) (Registrar's signature)

1233 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27
year 1943 hour 11 minute 30 PM

21. I hereby certify that I attended the deceased from Sept. 1,
_____, 1943, to Sept. 27, 1943;
that I last saw her alive on Sept 27, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Tumor of mid brain with intra cranial pressure

Due to _____

Due to _____

Other conditions 5nd
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy Tumor of mid brain

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 W. Ryan M.D. (M. D. or other) _____
Address Kirkpatrick Bldg Date signed 9-27-43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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..... *Josh C. Dumble*

Licensed Embalmer No. *3250*

P. O. Address. *Grant city 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.