

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42085

State File No. _____

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 165

1. PLACE OF DEATH:

(a) County Cooper

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

(c) Name of hospital or institution: Dr. C. H. Ravenswaay Clinic.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Minutes.
(Specify whether _____)

In this community 31 Years.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper

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

(d) Street No. 311-3rd. Street.
(If rural, give location)

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

If yes, name country ---

3. (a) PRINT FULL NAME Michael Carroll

3. (b) If veteran, name war ----

3. (c) Social Security No. ----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 33ⁿ
year 1943 hour 4 minute p. M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Elizabeth Carroll

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

7. Birth date of deceased Sept. 11ⁿ 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1943, to Dec 1943
that I last saw him alive on Dec 19 1943
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

82 3 13 hr. min.

Immediate cause of death myocarditis

Due to myocardial failure

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

Due to _____

Other conditions (Include pregnancy within 3 months of death) 932

10. Usual occupation Retired.

Major findings: Of operations _____

Of autopsy _____

11. Industry or business ---

12. Name Margin Carroll

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

14. Maiden name Sarah McFadden.

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Elizabeth Shine.

(b) Address Boonville, Mo.

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? _____

17. (a) Burial (b) Date thereof Dec. 27ⁿ/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cemetery.

23. Signature T. C. Beckett, MD.
Boonville MO Date signed 12-27-43

18. (a) Signature of funeral director Goodman & Holler

(b) Address Boonville, Mo.

19. (a) 12-28-43 (b) Dr Chas. Swep.
(Date received local registrar) (Registrar's signature)

1088

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

27
2

RECEIVED
City Health Officer No. 8.
Date Filed 1-5-44

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 J. H. Goodman
Licensed Embalmer No. 1178
P. O. Address Boonville, 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.