No. 2
—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 23 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6995

Registration District No. 94 Primary Registration District No. 5343 Registrar's No.

1. PLACE OF DEATH:

(a) County Dade
(b) City or town Arcola North Ward
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Arcola
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 54 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 29

(a) State Missouri (b) County Dade
(c) City or town Arcola
(If outside city or town limits, write "RURAL")
(d) Street No. Arcola
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3. (a) PRINT FULL NAME Louise Eldora Carson
3. (b) If veteran, name war No
3. (c) Social Security No. no
4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced widow 2
6. (b) Name of husband or wife Jerry Carson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased FEBRUARY (Month) 5 (Day) 1859 (Year)

8. AGE: Years 84 Months 11 Days 9 If less than one day hr. min.

9. Birthplace Harrison County (City, town, or county) Missouri (State or ~~foreign country~~)
10. Usual occupation House wife
11. Industry or business None

FATHER
12. Name No record
13. Birthplace No record (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name No record
15. Birthplace No record (City, town, or county) 9 (State or foreign country)

16. (a) Informant Alice Brooks
(b) Address Arcola
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Greenfield Cemetery
18. (a) Signature of funeral director Ward Funeral Home
(b) Address Greenfield
19. (a) 1-18-44 (Date received local registrar) (b) Kyle Kirby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14
year 1944 hour 5:00 minute a.M.
21. I hereby certify that I attended the deceased from Did not see except after 19 to 19
that I last saw h alive on death 19
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemmorhage

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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 3

23. Signature J. H. Jacques Coroner (M. D. or other)
Address 1-15-44 Date signed

1343

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 244-256
Date Filed FEB 8 1944

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 Sam L. Sensenney Jr

Licensed Embalmer No. 4099

P. O. Address Greenfield Mo.

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.

S. No. 2B
DM—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 94 Primary Registration District No. 5343 Registrar's No.

1. PLACE OF DEATH:

(a) County Dade

(b) City or town Arcola North Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution

(If not in hospital or institution, write street number or location)

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

In this community

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 Lavina E Carson

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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. 5 1880
(Month) (Day) (Year)

8. AGE: Years 84 Months 11 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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 Jan. day 4 year 1964 hour minute M.

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

Immediate cause of death Pulmonary Hemorrhage

Due to Tubercular Condition.

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.

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

NATIONAL SUPPLEMENTARY INFORMATION REQUESTED

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