

10. 2
1-5-42
5-17-39
X32873

FILED NOV 4 1944

Primary Registration District No. 5102

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Benton
(b) City or town Fristoe Twp. (Rural)
(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 1 (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Benton
(c) City or town (Rural) Fristoe
(If outside city or town limits, write "RURAL")
(d) Street No. Fristoe Twp.
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William A. Carson

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex male 5. Color or race white
6. (a) Single, married, divorced, widowed

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

7. Birth date of deceased August 21 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 1 9 hr. _____ min.

9. Birthplace Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Homer Carson
(b) Address Rt. 1 Brookline, Mo.

17. (a) Burial (b) Date thereof Oct. 2, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Turkey Creek Cemetery

18. (a) Signature of funeral director White-Reser
(b) Address Warsaw, Mo.

19. (a) 10/5/44 (b) Joao Logan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30
year 1944 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept 1, 1944 to Sept 30, 1944
that I last saw him alive on Sept 30, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death acute cholecystitis Duration 10 days

Due to Biliary Calculus 1 mo

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 126. PHYSICIAN
Of autopsy _____
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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Essentially J. D. D
Address Warsaw Mo Date signed 10/1/44

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

RECEIVED

Health Officer No. 7,

10-44-1193

Date Filed 11-3-44

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..... *Ronald W. Turpin*

Licensed Embalmer No. 3053

P. O. Address..... Warsaw, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 200
Registrar's No. 88

Registration District No. 30

Primary Registration District No. 5102

1. PLACE OF DEATH:
(a) County Benton
(b) City or town Practical Friable Trip
(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)

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 Wm A. Carson
(b) If veteran, name war..... (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February year 1944 hour..... minute..... M.
21. I hereby certify that I attended the deceased from....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death.....

4. Sex M 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

Duration
Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy.....

7. Birth date of deceased Aug 21 1886
(Month) (Day) (Year)
8. AGE: Years 27 Months 1 Days 1 (Less than one day) min.

9. Birthplace Jeru
(City, town, or county) (State or foreign country)

10. Usual occupation old age assistance

MOTHER FATHER
11. Industry or business.....
12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
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) 11/11/44 (b) Jas A. Logan
(Date received local registrar) (Registrar's signature)

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..... (M. D. or other).....
Address..... Date signed.....

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

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

SUPPLEMENTARY

33622