

No. 2
9-4-41
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

38951

FILED DEC 4 1944

State File No.

Registration District No. 327

Primary Registration District No. 4484

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Commerce
(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) 1

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

In this community 5 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott 10

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

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

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

If yes, name country _____

3. (a) PRINT FULL NAME Harriett Elizabeth Carlton

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 19 year 1944 hour 1 minute 50 A.M.

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Thomas Jefferson Carlton

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

7. Birth date of deceased April 16 1864
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 17 1944 to Jan 19 1944

that I last saw her alive on Jan 17 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Duration 1 week

8. AGE: Years 79 Months 9 Days 3

If less than one day _____ hr. _____ min.

Due to _____

Due to _____

Other conditions Senile Dementia
(Include pregnancy within 3 months of death)

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

10. Usual occupation House Keeper

11. Industry or business _____

MOTHER FATHER { 12. Name Dont know

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

14. Maiden name Dont know

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy § 201

16. (a) Informant John V. Carlton

(b) Address Commerce Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-44
(Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn St. Louis Co. Mo

18. (a) Signature of funeral director Bishop H. H. Hubbard

(b) Address Chaffee, Mo.

19. (a) _____ (b) _____
(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 Fred W. Martin, D.O. (M. D. or other) 1-19-44

Address Illmo, Mo Date signed _____

1036

(Licensed Embalmer's Statement on Reverse Side)

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.....

Glenn Wilson

Licensed Embalmer No.....

2828

P. O. Address.....

Jackson 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. See
Registrar's No. _____

Registration District No. 327 Primary Registration District No. 4484

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Commerce
(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 _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Harriet E. Corlton
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 April 16 1886
(Month) (Day) (Year)

8. AGE: Years 29 Months 9 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-22-44 (b) Ess E. Hankins
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan Day 9
Year 1944 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

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

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

SUPPLEMENTAL

38951