

No. 2  
 8-43  
 5-17-39  
 X37823

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS  
**FILED JAN 16 1945**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **3868**  
 Registrar's No. **212**

Registration District No. **360** Primary Registration District No. **6225**

**1. PLACE OF DEATH:**  
 (a) County Vernon  
 (b) City or town Nevada  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hosp No 3  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2  
 In this community 3yr 9mo 22d. (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** CARRIE-NORTHROP  
 3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex fem. 5. Color or race wh. 6. (a) Single, widowed, married, divorced widow  
 6. (b) Name of husband or wife Ernest Northrop 6. (c) Age of husband or wife if alive deceased years  
 7. Birth date of deceased Nov 24 1886 (Month) (Day) (Year)

**8. AGE:** Years 58 Months 0 Days 26 If less than one day - hr. - min.

**9. Birthplace** unknown Kansas (City, town, or county) (State or foreign country)

**10. Usual occupation** formerly housewife

**11. Industry or business** none

**12. Name** George Newton

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

**14. Maiden name** Sarah Hayes

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

**16. (a) Informant** Records State Hosp No 3

**(b) Address** Nevada Mo

**17. (a) Burial** (b) Date thereof 12-22-44 (Month) (Day) (Year)

**(c) Place: burial or cremation** Task Cemetery

**18. (a) Signature of funeral director** Ed C. Miller

**(b) Address** Carthage Mo

**19. (a) 12-23-44** (b) Edzel B. Beuch (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Jasper  
 (c) City or town Carthage (If outside city or town limits, write "RURAL")  
 (d) Street No. 510 Cedar (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 1

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Dec day 20 year 1944 hour 5 minute A M.

**21. I hereby certify that I attended the deceased from** Feb 25 1944 to Dec 20 1944  
 that I last saw him live on Dec 20 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 1 wk  
 Due to 107

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

Probly schizophrenic type  
 Major findings: no operations

Of autopsy no autopsy

**22. If death was due to external causes, fill in the following:** No.

(a) Accident, suicide, or homicide (specify) No.

(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** Paul L Barone (M. D. or other)

Address State Hosp No 3 Date signed 12/20

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

800

RECEIVED

District Health Officer No. 7,

District File Number 12-44-1451

Date Filed 1-8-45

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

*Ed [Signature]*

Licensed Embalmer No.

2222

P. O. Address

Quincy

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.