

FILED MAR 12, 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 5257

Registrar's No. _____

1. PLACE OF DEATH *Yellow Creek Jwp*
Chariton
(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: *Rural 1*
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community *68 years* (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME *Charles Carson*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *March* day *2*
year *1945* hour *2* minute *30* P. M.

4. Sex *male* 5. Color or race *white*
6. (a) Single, widowed, married, divorced *married*
6. (b) Name of husband or wife *Bertha Carson* 6. (c) Age of husband or wife if alive *57* years
7. Birth date of deceased *March - 22 - 1876*
(Month) (Day) (Year)

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 *killed on*
D.P. & F. Railway
M.P. 350.4
Duration _____

8. AGE: Years Months Days If less than one day
68 *11* *10* hr. _____ min.

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

9. Birthplace *Brookfield* *Mo*
(City, town, or county) (State or foreign country)

10. Usual occupation _____

MOTHER FATHER
11. Industry or business _____
12. Name *Charles Carson*
13. Birthplace *unknown*
(City, town, or county) (State or foreign country)
14. Maiden name *Amanda Stewart*
15. Birthplace *unknown*
(City, town, or county) (State or foreign country)

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) *Accident*
(b) Date of occurrence *Mar. 2 - 1945*
Where did injury occur? *Chariton Mo*
(City or town) (County) (State)
(c) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place) (e) Means of injury _____

16. (a) Informant *Mrs Bertha Carson*
(b) Address *Marceline Mo*

17. (a) *Burial* (b) Date thereof *March 4 1945*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *mt Olivet*
18. (a) Signature of funeral director *James M. Laughlin*
(b) Address *Marceline Mo*

19. (a) *MAR 3* (b) *MARTHA CLARK*
(Date received local registrar) (Registrar's signature)

23. Signature *W.D. West* (M. D. or other) *Carner*
Address *Marceline Mo* Date signed *3/2/45*

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

39-45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 66

Primary Registration District No. 5257

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Chazitan
(b) City or Rural Yellow Creek
(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 Charles Carson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased March 2 1898
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days _____ If less than one day _____ min.

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

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) _____ (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)

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 March year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ 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) _____
169-8
169-8

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Major findings: Of operations _____
Of autopsy _____
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) Accident - No
(b) Date of occurrence Mar 2 1945
(c) Where did injury occur? On railroad track (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In East Kansas City, Mo
Specify type of place _____
Where _____ (City or town) (County) (State)
23. Signature W. D. West (M. D. or _____)
Address Keosauqua Mo Date signed 3/10/45

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

SUPPLEMENTARY

JUN 5 1945

5835