

S. No. 2
-11-10-39
-5-17-39
P I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16787

State File No. _____

FILED JUN 12 1945

Registration District No. 107

Primary Registration District No. 5422

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Paris
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Independence Hosp
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dunklin ³⁵

(c) City or town Paris ¹¹
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Anna Carr

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 19
year 45 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from 1944
19 _____ 19 _____
that I last saw her alive on 4-15-45 1945
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Jan 10 1885
(Month) (Day) (Year)

Immediate cause of death Broncho Pneumonia

Duration _____

8. AGE: Years Months Days If less than one day

60 3 3 hr. _____ min.

Due to _____

Due to _____

Other conditions Asplenia
(Include pregnancy within 3 months of death)

9. Birthplace Carinthia, Miss!
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Carr

13. Birthplace Carinthia, Miss!
(City, town, or county) (State or foreign country)

14. Maiden name Zelpha M. Carr

15. Birthplace Carinthia, Miss!
(City, town, or county) (State or foreign country)

16. (a) Informant Kella Thompson

(b) Address Kenilworth, Mo. Ben Delaney

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

(c) Place: burial or cremation Open Ridge 4 20-45

22. If death was due to external causes, fill in 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 0

18. (a) Signature of funeral director Legy Funeral Home

(b) Address Kenilworth, Mo

19. (a) 5-4-45 (b) Julius B. Anderson
(Date received local registrar) (Registrar's signature)

23. Signature J. Thompson (M.D. or other) MD

Address Kenilworth, Mo Date signed 4/19/45

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

5
0
0

4701

RECEIVED
District Health Office No. 2
District File Number 645-794
Date Filed 6-6-45

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 *Walter A. Hawker*

Licensed Embalmer No. *2002*

P. O. Address *Hennett me*

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, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 44

Registration District No. 107 Primary Registration District No. 5422

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Rural Independence Twp
(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)

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 Anna Carr
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 16 1884 (Month) (Day) (Year)

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

8. AGE: Years 60 Months 3 Days 3 If less than one day _____ hr. _____ min.
9. Birthplace Miss (City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____ (State or foreign country)
15. Birthplace (City, town, or county) (State or foreign country)

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?

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) _____

While at work? (Specify type of place) _____ (c) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed _____

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

SUPPLEMENTARY

110787