

No. 2
8-43
17-39
K37823

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17483**

FILED JUN 29 1945
Registration District No. **024**

Primary Registration District No. **3042**

Registrar's No. **30**

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

1. PLACE OF DEATH:

(a) County Madison
 (b) City or town Fredericktown Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community her whole life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison
 (c) City or town Fredericktown
 (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 MARGARET-ELIZABETH-CARLTON
 (b) If veteran, name war _____
 (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16
 year 1945 hour 11 minute 40 A.M.
 21. I hereby certify that I attended the deceased from May 13
1945, to May 16, 1945
 that I last saw her alive on May 16, 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 divorced
 6. (b) Name of husband or wife Robt. Carlton
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 9 1874
 (Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage
 Due to Hypertension
 Due to _____
 Other conditions hypertension
 (Include pregnancy within 3 months of death)

8. AGE: Years 70 Months 10 Days 7
 If less than one day _____ hr. _____ min.
 9. Birthplace Madison Co. Mo.
 (City, town, or county) (State or foreign country)
 10. Usual occupation house

Major findings:
 Of operations _____
 Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____
 12. Name Caleb Shetley
 13. Birthplace Mo. D.
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah Bess
 15. Birthplace Madison Co. Mo. D.
 (City, town, or county) (State or foreign country)
 16. (a) Informant Mattie Palaty
 (b) Address Fredericktown Mo.
 17. (a) Burial (b) Date thereof May 18-1945
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Family Cemetery, Mad Co. Mo.
 18. (a) Signature of funeral director Wesley Hall
 (b) Address Fredericktown Mo.
 19. (a) May 18-1945 (b) S. A. Slaughter
 (Date received local registrar) (Registrar's Signature)
Ray S. Slaughter
 (Licensed Embalmer's Statement on Reverse Side)

22. If death was due to external causes, fill in the following:
 (c) 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?
 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature S. A. Slaughter (M. D. or other) _____
 Address 133 W. Main Fredericktown Date signed May 17 1945

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RECEIVED

Health Officer No. 4
District File Number 645-654
Date Filed 6-5-45

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. H. Webb
Licensed Embalmer No. 731
P. O. Address Fredericktown, Md.

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. 206

Primary Registration District No. 3042

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Fredericktown
(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 Margaret E. Carlton

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 wid

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

7. Birth date of deceased July 9 1943
(Month) (Day) (Year)

8. AGE: Years 20 Months _____ Days _____ If less than one day _____ hr. _____ 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) _____ (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) _____ (b) _____ (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 June Day 30 Year 1943 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 _____

Duration

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

Due to _____

Due to _____

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

PHYSICIAN

Major findings: Of operations _____

Of autopsy 1318

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 Schlaughts (M. D. or other) _____
Address Fredericktown mo Date signed 6/19/43

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

SUPPLEMENTARY

17483