

FILED SEP 12 1945

Registration District No. 55

Primary Registration District No. 5192

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Rural, Combs Twp.
(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 ANNA ELIZA GILBERT

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

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

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

7. Birth date of deceased June 19 1867
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Epperson

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

14. Maiden name Unknown

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

16. (a) Informant B. E. Gilbert

(b) Address Carrollton Mo.

17. (a) Burial (b) Date thereof 8-18-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cem.

18. (e) Signature of funeral director Stanley G. Gibson

(b) Address Carrollton Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll
(c) City or town Rural
(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 Aug. day 16
year 1945 hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from Aug 15 1945 to Aug 16 1945
that I last saw her alive on Aug 15 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____

mitral stenosis
in suffering 5 yrs.

Due to Age & wear

Due to Also abnormal tumor

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

Major findings: _____

Of operations _____

Of autopsy aut

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) _____

23. Signature A. Hamilton (M. D. or _____)

Address Carrollton Mo. Date signed Aug 16 1945

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1424

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 9-8-45.....

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton W

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. 51

Primary Registration District No. 5192

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Rural
(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 Anna E. Gilbert

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 _____

7. Birth date of deceased June 19 (Month) (Day) (Year)

8. AGE: Years 78 Months _____ Days _____ (Unless 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 18-16-45 (b) Mr Herbert Calvert (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 _____ Year 1945 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 _____

Due to _____

Due to _____

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

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) _____

(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

MOTHER FATHER

SUPPLEMENTARY

S-27051