

FILED NOV 28 1945

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 116

1. PLACE OF DEATH:

(a) County Hawell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: West Plains Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 hrs.
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Hawell
(c) City or town West Plains
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sadie Carroll

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

4. Sex 71 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Will Carroll 6. (c) Age of husband or wife if alive deceased
7. Birth date of deceased 12 10 1898
(Month) (Day) (Year)

8. AGE: Years 47 Months 9 Days 29 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name S.A. Ross
13. Birthplace Wisconsin (City, town, or county) (State or foreign country)
14. Maiden name Amanda Collins
15. Birthplace Hera (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ted Ballard

(b) Address Shayer, Mo

17. (a) B (b) Date thereof 9 9 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director Robertson

(b) Address West Plains, Mo.

19. (a) 11-6-1945 (b) Bludis Harrison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 9
year 1945 hour 3 minute 40 P.M.

21. I hereby certify that I attended the deceased from 9/9 45 to 9/9 45, 1945,
that I last saw him/her alive on 9/9 45, 1945,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Cerebral 7 240
fever

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

Major findings: _____
Of operations Hof
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?
_____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Maude Howard (M. D. or other) MD
Address West Plains, Mo. Date signed 10/13/45

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

RECEIVED

District Health Officer No. 5,

District File Number 1145-424

Date Filed 11-17-45

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 George Robertson

Licensed Embalmer No. 3435

P. O. Address West Haverhill

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.