

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 11 1946

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41676**
Registrar's No. **18**

Registration District No. **17** Primary Registration District No. **5652**

1. PLACE OF DEATH
(a) County **Lawrence**
(b) City or town **Miller R.R. #2**
(c) Name of hospital or institution: **L I**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1** (Specify whether)
In this community **Native**
years, months or days

3. (a) PRINT FULL NAME **Caroline Merritt**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife **Deceased**
6. (c) Age of husband or wife if alive **1** years
7. Birth date of deceased **10 - 12 - 1860**
(Month) (Day) (Year)

8. AGE: Years **79** Months **2** Days **8**
If less than one day
hr. min.

9. Birthplace **M. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Nathan Boyd**
13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Matilda Gregory**
15. Birthplace **Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ruby Merritt**
(b) Address **Miller Mo.**

17. (a) **Burial** (b) Date thereof **12 23 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **GREYS PALM**

18. (a) Signature of funeral director **Monius-Deiman**
(b) Address **Miller Mo.**

19. (a) **12-30-45** (b) **H.S. Burney**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Lawrence**
(c) City or town **Miller R.R. #2**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **None** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **20**
year **1945** hour **12** minute **20** P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____
that I last saw h. _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart attack**
myocardial infarction

Due to **arteriosclerosis**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 **H.S. Burney** (M. D. or other)
Address **Miller Mo.** Date signed **1-2-46**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1054

RECEIVED

District Health Officer No. 6,

District File Number 146-17

Date Filed JAN 8 1946

MAR 22 1946

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

G. R. Lemon

Licensed Embalmer No.

3897

P. O. Address

Miller Mo

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JanRegistrar's No. 18Registration District No. 176Primary Registration District No. 5652

1. PLACE OF DEATH:

- (a) County Lawrence
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Red Oak Hosp - Rural
 (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 Caroline Merritt

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 _____ years

7. Birth date of deceased Oct 12, 1868
(Month) (Day) (Year)8. AGE: Years 77 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER {
 12. Name unknown
 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)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 3-11-46 (b) W. J. Beatty
(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. Red Oak Hosp (If rural, give location)
 (e) Citizen of foreign country? Rural (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ year _____ 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 _____

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 W. J. Beatty (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAR 22 1946

41676