

FILED JUN 12 1946

Registration District No. **55**

Primary Registration District No. **3011**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Carroll**
 (b) City or town **Carrollton**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Staton Clinic
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 Days**
(Specify whether years, months or days)

3. (a) PRINT

FULL NAME **Donna Kay Endicott**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F-Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **March 31 1946**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		1	23	hr. _____ min. 0

9. Birthplace **Carroll County**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Earl Endicott**

13. Birthplace **Joplin Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Maud Grandon**

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

16. (a) Informant **Earl Endicott**

(b) Address **Wakenda Mo R R**

17. (a) **Burial** (b) Date thereof **May 25th**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Adkins Cemetery**

18. (a) Signature of funeral director **P. T. Marshall**

(b) Address **Carrollton Mo**

19. (a) **May 26th** (b) **Mr. J. H. Caldwell**
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Carroll**
 (c) City or town **Wakenda Mo Rural Route**
(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 **May** day **24** 1946
 year _____ hour **4:00** minute _____ P. M.

21. I hereby certify that I attended the deceased from **May 19** 19**46** to **May 24** 19**46**
 that I last saw her alive on **May 24** 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Inadequate assumption of food - Indigestion
J. R. A. Blood factor

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

Major findings: Of operations _____

Of autopsy **158**

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 **P. T. Marshall** Date signed **June 6 1946**
 Address **Carrollton, Mo**

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 10-11-46

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 myself

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed P. M. Marshall

Licensed Embalmer No. 25-25

P. O. Address Carrollton 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.