

FILED JUL 12 1946

State File No. _____

Registration District No. 226

Primary Registration District No. 4337

Registrar's No. 20

1. PLACE OF DEATH:
(a) County Monroe
(b) City or town Madison
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Monroe
(c) City or town Madison (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 _____

3. (a) PRINT FULL NAME Emma Cornelia McCarroll
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife J. P. McCarroll 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased 12-7-1869
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 13 year 1946 hour 1 minute P. M.
21. I hereby certify that I attended the deceased from May 1, 1946, to May 13, 1946; that I last saw her alive on May 13, 1946; and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 5 Days 6 If less than one day _____ hr. _____ min.

Immediate cause of death Cancer of Intestines, Ulcer of Hip Duration 3 yrs.
Due to _____
Due to _____

9. Birthplace Clifton Hill Mo. U
(City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

10. Usual occupation housewife
11. Industry or business at home

MOTHER: 12. Name William Hackman
13. Birthplace Putnam Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Fannie Waller
15. Birthplace Randolph Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant J. P. McCarroll
(b) Address Madison Mo

17. (a) Home (Burial, cremation, or removal) (b) Date thereof 5-15-46
(Month) (Day) (Year)
(c) Place: burial or cremation Spring Hill cemetery

18. (a) Signature of funeral director F. W. Thompson
(b) Address Madison Mo

19. (a) May 15 1946 (Date received local registrar) (b) Clara Little (Registrar's signature)

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? _____

23. Signature J. P. Turner (M. D. or other) 21
Address Madison Mo Date signed 5-13-46

RECORDED

District Health Officer No. 10

District File Number 7-46-1344

Date Filed JUL 1 1 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

Mrs. Freda Thompson

Licensed Embalmer No. 3282

P. O. Address Madison 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 200

Registration District No. 226

Primary Registration District No. 4337

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town Madison
(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

Emma C. McCamee

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

4. Sex F 5. Color or race W 6. (a) Single, with in married, divorced _____

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

7. Birth date of deceased Mar 7
(Month) (Day) (Year)

8. AGE: Years 76 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 _____

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 May 1946 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: 152
Of operations _____
Of autopsy _____

Duration

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 W. E. Turner (M. D. or other) 200
Address Madison MO Date signed 7-23-46

SUPPLEMENTARY

MOTHER FATHER

20985