S. No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 7 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35946

Registration District No. 973 Primary Registration District No. 4545 Registrar's No. 63

1. PLACE OF DEATH:
(a) County Webster
(b) City or town Marshfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: x
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution x (Specify whether years, months or days)
In this community life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Webster
(c) City or town Marshfield
(If outside city or town limits, write "RURAL")
(d) Street No. x
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country x

3. (a) PRINT FULL NAME William Nelson Carroll
3. (b) If veteran, name war x
3. (c) Social Security No. x
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Sarah Roxy Ann Carroll
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased April - 3 - 1874 (Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 0 If less than one day x hr. x min.

9. Birthplace North Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Chair-maker
11. Industry or business Home
MOTHER FATHER
12. Name Charley Carr
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Nancy Rice
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Sarah Carroll
(b) Address Marshfield - Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-46 (Month) (Day) (Year)
(c) Place: burial or cremation Marshfield, Mo.
18. (a) Signature of funeral director [illegible]
(b) Address [illegible]
19. (a) 10/31/46 (Date received local registrar) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3 year 1946 hour 6 minute A.M.
21. I hereby certify that I attended the deceased from Sept. 20, 1946 to Oct. 3, 1946 that I last saw him alive on Oct. 2, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate Gland — Duration: Year, about
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

51B

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 C. P. Macdonnell (M. D. or other) M.D.
Address Marshfield, Mo. Date signed Oct. [illegible]

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 1146-1099
Date Filed NOV 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 Lex Lainey

Licensed Embalmer No. 3312

P. O. Address Marsh Field

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.