

S. No. 2
OM-5-43
v. 5-17-39
I X36671

FILED AUG 13 1947

Registration District No. **1**

Primary Registration District No. **3011**

Registrar's No. **204**

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: **Mrs Youngs Nursing Home**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 weeks**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Carroll 17**

(c) City or town **Carrollton**
(If outside city or town limits, write "RURAL")

(d) Street No. **1**
(If rural, give location) **0**

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Harvey Lewis Booth**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **20th** year **1947** hour **8:20** minute **A** M.

4. Sex **M** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **widowed**

6. (b) Name of husband or wife **Hattie Godsey**

6. (c) Age of husband or wife if alive **Dec 10th 1865** years (Day) (Year)

7. Birth date of deceased **February 10th 1865**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **June 1**, 19**47** to **June 20**, 19**47**; that I last saw him alive on **June 17**, 19**47**; and that death occurred on the date and hour stated above.

8. AGE: Years **82** Months **4** Days **10** If less than one day hr. min.

Immediate cause of death **Cerebral Thrombosis**

Due to _____

Due to _____

9. Birthplace **Richmond Virginia 1**
(City, town or county) (State or foreign country)

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

Major findings: _____

Of operations _____

Of autopsy **§ 3 B**

10. Usual occupation **Retired**

11. Industry or business _____

MOTHER FATHER { 12. Name **Don't Know**

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

14. Maiden name **Don't Know**

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **Social Security office**

(b) Address **Carrollton Missouri**

17. (a) **burial** (b) Date thereof **6/22/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rock Springs Cem, Tiana Mo.**

18. (a) Signature of funeral director **Clifford W. Austin**

(b) Address **Tiana Missouri**

19. (a) **6/21/47** (b) **Mr. Herbert Calcutt**
(Date received local registrar) (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? **No.**

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature **Miss H. Blunt M.D.** (Physician's name)

Address **Carrollton Mo** Date signed **6/20**

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 8-2-47

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 Clifford W. Auster

Licensed Embalmer No. 3233

P. O. Address Tina, Missouri

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..