

FILED DEC 27 1948  
Registration District No. 2789

Primary Registration District No. 5-95-7

I. PLACE OF DEATH:

(a) County Pike  
(b) City or town Canada  
(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 Mo (b) County Pike  
(c) City or town Canada  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME William R. Garrold  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month Dec 15<sup>th</sup> day \_\_\_\_\_  
year 1948 hour 9 minutes 30 a. m.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from May 30th  
\_\_\_\_\_ 1948 to June 1st 1948  
that I last saw him alive on May 30th 1948  
and that death occurred on the date and hour stated above.

7. Birth date of deceased Nov 27 1874  
(Month) (Day) (Year)

Immediate cause of death General Paralysis  
Duration \_\_\_\_\_

8. AGE: Years 74 Months 0 Days 18  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Hemiplegia Right Side  
Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation Retired

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Dorith Jensen  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name Dorith Jensen  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs Ray Morrow

(b) Address Canada, Mo.

17. (a) Burial (b) Date thereof Dec 16-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Harry Garrold

(b) Address Clarksville, Mo.

19. (a) 12-27-48 (b) Sude Richard  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
28. Signature Robert G. Grier (M. D. or other) \_\_\_\_\_  
Address Camden, Mo. Date Dec 15th 48

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

RECEIVED

District Health Officer No. 10

District File Number 12-48-2193

Date Filed DEC 23 1948

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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 Harry L. Carroll

Licensed Embalmer No. 2439

P. O. Address \_\_\_\_\_

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, above space should be left blank.