

FILED MAY 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11688

BIRTH NO. 49-121044 REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 154

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived? If institution: residence before admission). a. STATE Mo b. COUNTY Callaway	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fulton		c. LENGTH OF STAY (in this place) 8 Hrs	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fulton		14	
d. FULL NAME OF HOSPITAL OR INSTITUTION Callaway Hospital 0		d. STREET ADDRESS (If rural, give location) RFD #2 0	
3. NAME OF DECEASED (Type or Print) a. (First) Sandra		b. (Middle) Gayle	
c. (Last) Carwile		4. DATE OF DEATH (Month) (Day) (Year) May 5 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH May, 5, 1949
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Fulton, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Archie Woodrow Carwile	
13b. MOTHER'S MAIDEN NAME Betty Louise Moore		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Archie W. Carwile		ADDRESS Fulton, Mo. R2	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetic Toxemia ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes Mellitus (mother) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 5-5, 1949 to 5-5, 1949 that I last saw the deceased alive on 5-5, 1949, and that death occurred at 3:50 m., from the causes and on the date stated above.	
23a. SIGNATURE John A. Brown M.D.		23b. ADDRESS Fulton Mo -	
23c. DATE SIGNED 5-6-49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE May-6-1949		24c. NAME OF CEMETERY OR CREMATORY Hillcrest	
24d. LOCATION (City, town, or county) (State) Fulton, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Maretta Lawrence	
25. ADDRESS 426 Thallace Funeral Home, Fulton Mo		DATE REC'D BY LOCAL REG. May-6-1949	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 9,
District File Number
MAY 11 1949
Date Filed

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Denzil C. Browning

Licensed Embalmer No. *2724*

P. O. Address *Fulton*

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.