

FILED NOV 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33191**

14

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **362**

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) Fulton 2		c. CITY (If outside corporate limits, write RURAL and give township) Malta Bend 97	
c. LENGTH OF STAY (In this place) 6 mo 22 dy		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hosp no 1			

3. NAME OF DECEASED (Type or Print) Pearl (First) Ann (Middle) Carl (Last)			4. DATE OF DEATH Oct 27 1949 (Month) (Day) (Year)		
5. SEX Female		6. COLOR OR RACE negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never	
8. DATE OF BIRTH Sept 12 1881		9. AGE (In years last birthday) 68		10. CITIZEN OF WHAT COUNTRY? American	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	

13a. FATHER'S NAME Jno Carl		13b. MOTHER'S MAIDEN NAME May Ann Crawford		14. NAME OF HUSBAND OR WIFE Susie Carl	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) DK		16. SOCIAL SECURITY NO. DK		17. INFORMANT'S SIGNATURE OR NAME Records State Hosp no 1 Fulton 2 ADDRESS	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) generalized atherosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 4221	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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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 **Oct 1**, 1949, to **Oct 27**, 1949, that I last saw the deceased alive on **Oct 24**, 1949, and that death occurred at **3:09** m., from the causes and on the date stated above.

23a. SIGNATURE M. G. Miller M.D. (Degree or title)		23b. ADDRESS State Hosp no 1 Fulton 2		23c. DATE SIGNED 10-27-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct 30 1949		24c. NAME OF CEMETERY OR CREMATORY Malta Bend Mo		24d. LOCATION (City, town, or county) (State) Malta Bend Mo	
DATE REC'D BY LOCAL REG. Oct 27 1949		REGISTRAR'S SIGNATURE Martha Lawrence 426		25. FUNERAL DIRECTOR'S SIGNATURE Leo Sheu ADDRESS Malta Bend Mo			

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

~~District File Number~~
District Health Officer
RECEIVED
OCT 29 1919

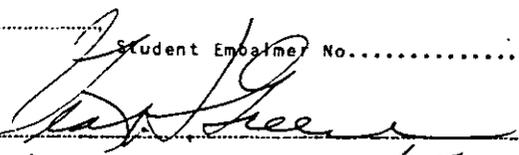
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Student Embalmer No.

Signed



Signed.....
Student Embalmer

Licensed Embalmer No. 4220

P. O. Address Marshall

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.