

FILED JAN 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **1646**  
Registrar's No. **6**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **175** PRIMARY REG. DIST. NO. **5650**

1. PLACE OF DEATH a. COUNTY <b>Lawrence</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lawrence</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Spring River</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Spring River</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Rural Verona</b>		d. STREET ADDRESS (If rural, give location) <b>Near Verona</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>August</b>	b. (Middle)	c. (Last) <b>Carlson</b>	4. DATE OF DEATH (Month) (Day) (Year)	<b>1 11 50</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>12-28-1864</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Smoland, Sweden</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>unknown</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Louise Carlson</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>John E. Carlson</b>	ADDRESS <b>Aurora</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Adenocarcinoma of submaxillary glands</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>1421</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Senility</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Sept 10, 1949** to **Jan 10, 1950**, that I last saw the deceased alive on **Sept 9, 1950**, and that death occurred at **4:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>F. Avery Watson, D.O.</b>	23b. ADDRESS <b>Verona, Mo</b>	23c. DATE SIGNED <b>Jan 11, 1950</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Jan 13-50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Spring River Cemetery, Verona</b>	24d. LOCATION (City, town, or county) (State) _____
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DATE REC'D BY LOCAL REG. <b>Jan 12-50</b>	REGISTRAR'S SIGNATURE <b>Ora Mc Natt</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>William W. Wood</b>	ADDRESS <b>Aurora</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JAN 16 1950  
District Health Office No. 6,  
District File Number 150-107  
Date Filed 1-19-50

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 William W. Wood

Licensed Embalmer No. 4539

P. O. Address Aurora, Ill.

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.