LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Henry

Township Leesville
or
Village Leesville
or
City Clinton 1110

Registration District No. 350 File No. 24399 a

Primary Registration District No. Leesville Registered No. 159-20-2

(NO. ..... St. ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Carl Junior Carlton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word)
Male	White	

6 DATE OF BIRTH Jan. (Month) 12 (Day) 1919 (Year)

7 AGE 1 yrs. 6 mos. ds. If LESS than 1 day, 2 hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) Leesville Mo

PARENTS

10 NAME OF FATHER C. C. Carleton

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Leesville Mo

12 MAIDEN NAME OF MOTHER Edith Albin

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Coal. Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. B. Albin

(Address) Clinton Mo

15 Filed 7/14 1920 W. B. B. Barr Registrar
350

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 12 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 4 1920, to July 12 1920,
that I last saw h.... alive on July 12 1920
and that death occurred, on the date stated above, at 1.00 p. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel H. Prague M. D.

7/14 1920 (Address) Clinton Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL 7/14 1920

20 UNDERTAKER — ADDRESS —

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County ..... Howard

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (No. ....., ... St., ... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to ....., 191.....,

that I last saw h.....alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS