S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 25 1947

Registration District No. 128

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5466

State File No. 37815

Registrar's No. 952

**1. PLACE OF DEATH:**

(a) County GREENE

(b) City or town Rural-S. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or Institution:
OZARK OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3. Days. (Specify whether years, months or days)
In this community 3. Days.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Pulaski

(c) City or town Laquey
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) /

If yes, name country

3. (a) PRINT FULL NAME William F. Carroll

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bashby Carroll

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Nov. (Month) 4 (Day) 1872. (Year)

8. AGE: Years 74 | Months 11 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Miller County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name John Carroll
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Poop
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Arthur Carroll
(b) Address Waynesville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/47 (Month) (Day) (Year)
(c) Place: burial or cremation Crocker, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 11-4-47 (Date received local registrar) (b) W E Hinckley M.D. (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 3 year 1947 hour 9:30 minute P M.

21. I hereby certify that I attended the deceased from Nov 1 1947 to Nov 3 1947; that I last saw him alive on Nov 3 1947 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Diabetic Acidosis | |
| Due to: Diabetes mellitus | |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): | |

Major findings:
Of operations (0)
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature R. A. Michael M.D. (Coroner or other)
Address Springfield Mo. Signed 11-3-47

(Licensed Embalmer's Statement on Reverse Side)

## 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. Walter E Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield Mo

**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.**