

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

Do not use this space.

18549

1. PLACE OF DEATH

County Bates

Registration District No. 50

File No. _____

Township _____

Primary Registration District No. 3004

Registered No. 30

City Butler (No. _____)

St. _____ Ward _____

2. FULL NAME

Mrs. Carrie Engle

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

M Engle

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 15 1874

7. AGE

YEARS

MONTHS

DAYS

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

56

3

3

8. OCCUPATION OF DECEASED

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

Housewife

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14. INFORMANT

(Address)

M Engle
Adrian Mo.

15. FILED

6/19 1930 - Nina L Culver

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 18th 1930

17. I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to June 17, 1930, that I last saw h. e. alive on June 12, 1930, and that death occurred, on the date stated above, at 2 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia

CONTRIBUTORY (SECONDARY) Peritonitis (duration) _____ yrs. _____ mos. 5 ds.

(duration) _____ yrs. _____ mos. Some ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

at Place of death

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) E. E. Robinson, M. D.

6/19, 1930 (Address) Adrian, Missouri

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Oak Hill

June 19 1930

20. UNDERTAKER

Culver

ADDRESS

Butler Mo.

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.

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LABORATORY OF THE FBI
WASHINGTON, D. C.

APPROVED FOR RELEASE
BY THE DIRECTOR

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JAN 26 1944

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Bates Registration District No. 30 File No.
 Township Primary Registration District No. 3004 Registered No. 30
 City Butler (No.) St. Ward)

2. FULL NAME Mrs Carrie Engle
 (a) Residence No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX f 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED m
 (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 18 1930

17. I HEREBY CERTIFY, that I attended deceased from to 19..... that I last saw h. alive on 19..... and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Broncho
 (duration) yrs. mos. da.

CONTRIBUTORY Peritonitis
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, 1000
 DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.
 , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT (Address)

15. FILED 8/18 1930 Minie L Culver REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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. FEE STARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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