

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.

MAY 25 1934

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

Do not use this space.

## 1. PLACE OF DEATH

County Howell  
Township Myart  
City (No. ....) .....

Registration District No. 389  
Primary Registration District No. 5543

File No. 12708  
Registered No. ....  
St. .... Ward)

## 2. FULL NAME

(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 <u>F</u>	4. COLOR OR RACE <u>Wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Thomas Carlsson</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Apr 13 - 1910</u>		
7. AGE	YEARS <u>24</u>	MONTHS .....
	DAYS <u>20</u>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....	
	10. Date deceased last worked at this occupation (month and year) .....	11. Total time (years) spent in this occupation <u>full</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Howell Co Mo</u>		
FATHER	13. NAME <u>Wah Burch</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Howell Co Mo</u>	
MOTHER	15. MAIDEN NAME <u>Darl Orey</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Howell Co Mo</u>	
17. INFORMANT <u>Ive Burch</u> (ADDRESS) <u>Kashimong Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Meredieth Cem</u> DATE <u>Apr 14, 1934</u>		
19. UNDERTAKER <u>Page Robertson</u> (ADDRESS) <u>West-Plains Mo</u>		
20. FILED <u>Apr 13, 1934</u> <u>HA Thompson</u> Registrar.		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 13, 1934

22. I HEREBY CERTIFY, That I attended deceased from Illc 1933 to Apr 13, 1934

I last saw her alive on Illc 18, 1933. Death is said to have occurred on the date stated above, at 10.4 m.

The principal cause of death and related causes of importance were as follows:

Tuberculosis of Lungs Date of onset 1928

Other contributory causes of importance:  
U. S. of Intestine

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ....., 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify HA Thompson (Signed) HA Thompson, M. D.  
(Address) Lawton Mo

