

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

Do not use this space.
20097
File No. 267
Registered No. _____
Ward) _____

1. PLACE OF DEATH

County Platte Registration District No. 319
Township Springfield Ordinary Registration District No. 2001
City Sumner Ward) _____

2. FULL NAME

(a) Residence, No. 1523 Oakwood 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 Male 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 15 - 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day hrs. min.
67 3 20 0 0 0

8. Trade, profession, or particular kind of work done, as shoemaker, sawyer, bookkeeper, etc. None

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 _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sumner Mo

13. NAME Charles Carr

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Delaware

15. MAIDEN NAME Mary Taylor

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Delaware

17. INFORMANT (ADDRESS) Wm. Taylor

18. BURIAL, CREMATION, OR REMOVAL PLACE Springfield DATE July 13 1934

19. UNDERTAKER (ADDRESS) Springfield

20. FILED 6-12 1934 Springfield

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/10 1934

22. I HEREBY CERTIFY That I attended deceased from Oct 1932 to June 10 1934

I last saw him alive on June 10 1934 Death is said to have occurred on the date stated above, at 7:20 a.m.

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

Carcinoma of the Lung
Chronic epatitis

Other contributory causes of importance:
 Surgery to left hip from fall June 17 1934

Name of operation 1933 Date of _____

What test confirmed diagnosis? 1933 Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury _____, 1934
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 C. Beckins M. D.
(Signed) 318 1/2 College
(Address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

051 22 35 29 27

151 7

1032

MAY 7 1961

Greene

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Cornelius J Carr
Who died at _____ on June 10 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex m Color or race w Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 62 Months 3 Days 25

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Carcinoma of Lung Chronic Cystitis Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) Injury to left leg from
Birthplace of mother (State or country) fall June 7th 1934
Principal cause of death: In home, Patrol, fractured hip

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 1934
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician C. B. Etkens - 318 1/2 College
Address of physician _____

Signature of Registrar _____ Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 318
Primary Reg. Dist. No. 2001

Very truly yours,
E. T. McLaugh
State Registrar

Special Agent.

STATE OF CALIFORNIA
COUNTY OF LOS ANGELES

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