

WHITE 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.

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

NOV 20 1934

Do not use this space.

Dr. Conner
File No. 33624
Registered No. 194
St. _____ Ward _____

1. PLACE OF DEATH

County Carroll Registration District No. 651
Township Center Prairie Primary Registration District No. 3862
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-8-1933

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
0 11 25

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
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) Carrollville, Mo.

MOTHER
13. NAME Alford Beck

14. BIRTHPLACE (CITY OR TOWN): (STATE OR COUNTRY) _____

15. MAIDEN NAME Sula Holt

16. BIRTHPLACE (CITY OR TOWN): (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) Alford Beck

18. BURIAL, CREMATION, OR REMOVAL PLACE Walter Cemetery DATE 9-14 1934

19. UNDERTAKER (ADDRESS) W. S. Smith

20. FILED Nov 6 1934 Aida Martin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-9 1934

22. I HEREBY CERTIFY, That I, attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at 11-430.

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

Colony Infection
1198
Date of onset 8-23-34

Other contributory causes of importance: HA

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 _____

(Signed) Alford Beck, M. D.

(Address) Carrollville, Mo

