

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
1939
Registration District No. 135

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35734
State File No. _____
Registrar's No. 117

Primary Registration District No. 5188

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Rose Remires
8. (b) If veteran, name war _____
8. (c) Social Security No. _____

4. Sex Female
5. Color or race Mexican
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if _____ years
7. Birth date of deceased Apr. 27 1939
(Month) (Day) (Year)

8. AGE: Years _____ Months 5 Days 13 If less than one day _____ min.

9. Birthplace Kansas City, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____
12. Name Manuel Remires
13. Birthplace Meriden, Mo
(City, town, or county) (State or foreign country)
14. Maiden name Ramona Contreras
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Manuel Remires
(b) Address Carrollton, Mo

17. (a) Burial (b) Date thereof 10-12-1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cem

18. (a) Signature of funeral director Walter Standa
(b) Address Carrollton, Mo

19. (a) 10-11-39 (b) W. H. Steuking
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Carroll
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 10
year 1939 hour 7 minutes 00 a. m.
21. I hereby certify that I attended the deceased from 10-10-39
to 10-10-39, 1939
that I last saw her alive on 10-10-39, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
Duration 3 days

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature W. H. Steuking (M. D. or other) M. D.
Address Carrollton, Mo Date signed 10-11-39

RECEIVED
District Health Officer No. 8,
District File Number
11/7/39
Date Filed

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 Ben W. Gibson
Licensed Embalmer No. 2961
P. O. Address Carrollton, Ga.

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, above space should be left blank.