

JUN 13 1940

235

Primary Registration District No.

5220

Registrar's No.

1. PLACE OF DEATH:

(a) County Dade  
(b) City or town Dadeville (South Morgan)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 30 yrs. years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade  
(c) City or town Dadeville, Mo. (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Cecil Robert Carns <sup>62</sup>

3. (b) If veteran, name war none 8. (c) Social Security No. 702-07-8778

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Mary Webb 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased June 9 1904  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
35 11 13 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Dade County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer and laborer

11. Industry or business Farming

12. Name Charles B. Carns

13. Birthplace Dade County Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Willet Womack

15. Birthplace Tenn.  
(City, town, or county) (State or foreign country)

16. (a) Informant John A. Carns

(b) Address Aldrich, Mo. R.F.D. #1.

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Long Cemetery

18. (a) Signature of funeral director W. L. B. Edwin

(b) Address Dadeville, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22  
year 1940 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

what I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death gun shot in left breast  
Due to suicide

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. W. Ward (M.D. or other) Cornor  
Address Greenfield, Mo. signed J

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

29

691

**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 \_\_\_\_\_

*Personally* \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed *William D. Ewing* \_\_\_\_\_

Licensed Embalmer No. *3092* \_\_\_\_\_

P. O. Address *Palmer Mo*  
*and Sedellville Mo* \_\_\_\_\_

**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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 18278

Registration District No. 235

Primary Registration District No. 5.320

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Dade  
(b) City or town South Morgan T.P.  
(If outside city or town limits, write "RURAL" and name of township)  
(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

3. (a) PRINT FULL NAME Cecil Robert Casus

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced Div

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 35 Months 11 Days 13 If less than one year, hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director William B. Erwin

(b) Address Dadeville, Miss

19. (a) June 9 1940 (b) Miss (c) Miss (d) \_\_\_\_\_  
(Date received local registrar) (County) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. \_\_\_\_\_ years.

20. DATE OF DEATH. Month May day 27 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 J. H. Ward (M. D. or other)

Address Greenfield, Miss Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **18278**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **235**

Primary Registration District No. **3320**

Registrar's No. ....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
ROWENA MOORE

1. PLACE OF DEATH:

(a) County Dade

(b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)

(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 years, months or days)

In this community.....

3. (a) PRINT FULL NAME Cecil Robert Carnes

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced. Div

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day h. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....  
(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 May day 22 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death gun shot in breast

Due to suicide

Due to.....

Other conditions. (Include pregnancy within 3 months of death) 167

Major findings: Of operations.....

Of autopsy.....

Duration

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) Suicide

(b) Date of occurrence. May 22-1940

(c) Where did injury occur? Dadeville Dade Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home of Frank Meek  
(Specify type of place) (e) Means of injury.....

23. Signature J. H. Ward (M. D. or other)

Address Greenfield Mo Date signed.....

SUPPLEMENTAL