

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

18766

State File No. _____

Registration District No. 408

Primary Registration District No. 5562

Registrar's No. 103

1. PLACE OF DEATH:
 (a) County Casper
 (b) City or town Carthage - Marion Township
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Route 2 - Carthage
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 0
 In this community 73 years (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Jennie CARRUTH
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 5 day 5
 year 1940 hour 7 minute 40 A. M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife H. L. Carr
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased December 29 1866
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 10, 1940, to May 5, 1940
 that I last saw her alive on April 15, 1940
 and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 4 Days 6
 If less than one day _____ hr. _____ min.

Immediate cause of death Chronic Bright's Disease
 Duration _____

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

Due to Age
 Due to 121

10. Usual occupation Housekeeper

Other conditions (include pregnancy within 3 months of death) _____

11. Industry or business _____
 MOTHER FATHER {
 12. Name Frank Caspers
 13. Birthplace Indiana
 (City, town, or county) (State or foreign country)
 14. Maiden name Maggie Creamer
 15. Birthplace Carthage Missouri
 (City, town, or county) (State or foreign country)

Major findings: Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs. Maggie Miller
 (b) Address Route 2 - Carthage, Mo
 17. (a) Burial (b) Date thereof May 7, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Fisher Cemetery
 18. (a) Signature of funeral director Kneel M. Astudy
 (b) Address Carthage, Mo
 19. (a) May 7, 1940 (b) E. J. M. Intine, M.D.
 (Date rec'd of local registrar) (Registrar's signature)

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 KEBAKER, M.D. (M. D. or other) _____
 Address Carthage, Mo Date signed _____

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.

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.....
Emma R. Stuebel

Licensed Embalmer No. *391*

P. O. Address *Bartholomew*

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.