

ED OCT 12 1940

Registration District No. **135**

Primary Registration District No. **3010**

Registrar's No. **90**

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(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 2
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Laura B. Tomlin

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

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, divorced, Widowed

6. (b) Name of husband or wife Geo. D. Tomlin 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 14 1868
(Month) (Day) (Year)

8. AGE: Years 72 Months 2 Days 12 If less than one day _____
by _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Wm E. Buchanan

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

14. Maiden name Sarah M. Wallace

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

16. (a) Informant Mrs Sam White

(b) Address Carrollton Mo

17. (a) Burial (b) Date thereof 9 28 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Betty Camp

18. (a) Signature of funeral director Stacy Day

(b) Address Carrollton Mo

19. (a) 9-27-40 (b) Wm H. Haskins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
(c) City or town Carrollton
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26th
year 1940 hour 1:15 minute P M.

21. I hereby certify that I attended the deceased from Sept. 17, 1940
to Sept. 26, 1940
that I last saw h w alive on Sept. 26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death 1 1/2 pints pneumonia

Due to Burns ✓
Stroke

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) Accidental
(b) Date of occurrence Sept. 15, 1940
(c) Where did injury occur? Carroll County, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home of friend

While at work? Yes (Specify type of place)
(e) Means of injury Burns ✓ 3

23. Signature Dr. Ernest L. Smith (M.D. or other) D.O

Address Tina, Mo Date signed 9/27/40

Duration

4 days
13 days
13 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

181
2.11

RECEIVED
District Health Officer No. 8,
District File Number 10-4-40
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, fact should be so stated above.

1-4
X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31648

Registration District No. 135-

Primary Registration District No. 3010

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(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

Laura B Tomlin

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced and
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 72 Months 2 Days 12 If less than one day _____ hr. _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

(Date received local registrar)

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 Sept day 26
year 1940 hour _____ minute _____ M.

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

Immediate cause of death Hypostatic pneumonia
Burns from burning building
shock

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

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) acc
(b) Date of occurrence Sept 18 - 1940
(c) Where did injury occur Carroll Co mo
(City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
1 home of friend
While at work? _____ (Specify type of place) Means of injury _____

23. Signature A. E. Smith (M. D. or other) DO
Address Tina Date signed No

SUPPLEMENTAL

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

