

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.

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Lebanon, Missouri

(c) Name of hospital or institution: Louise S. Wallace Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution two days
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Heta Idell Carlsson

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female

5. Color or race white

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

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

6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased: Aug. 9 1918
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>22</u>	<u>2</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace: Paris, Missouri Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name Ray Brimes

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

14. Maiden name May Gladys Embree

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

16. (a) Informant's own signature Mae Wolf

(b) Address 116 A S. Clark, Moberly, Mo.

17. (a) burial (b) Date thereof Oct 31 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Madison, Missouri

18. (a) Signature of funeral director E. N. Stewart

(b) Address Madison, Mo.

19. (a) 10-29-40 (b) J. M. Colcut
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede

(c) City or town Lebanon, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. rural
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29
year 1940 hour 6 minute 45 A. M.

21. I hereby certify that I attended the deceased from 10-27 to 10-29, 1940
that I last saw her alive on 10-28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute yellow atrophy of liver Duration 3 days

Due to (etiology unknown positive)

Due to _____

Other conditions pregnancy 6 1/2 mo
(include pregnancy within 6 months of death)

terminated 10-27-40

PHYSICIAN

Major findings: _____

Of operations: _____

Of autopsy: 120

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 Page 1 (M. D. or other) _____

Address Madison, Mo. Date signed 10-29-40

DEC 30 1946

RECEIVED
District Health Officer No. 7,
District File Number 11-40-1626
Date Filed 11-13-40

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

E. M. Stewart

Registered Apprentice No. 1885-

working under my personal supervision.

Signed

E. M. Stewart

Licensed Embalmer No. 1885-

P. O. Address Halifax, N.S.

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.