

Registration District No. **502**

Primary Registration District No. **K305**

Registrar's No. **36**

1. PLACE OF DEATH:

(a) County **LINN**
 (b) City or town **MARCELINE MO**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
PUTMAN HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **30 hrs**
(Specify whether)
 In this community **40 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **LINN**
 (c) City or town **MARCELINE**
(If outside city or town limits, write "RURAL")
 (d) Street No. **127 West Ritchie**
(If rural, give location)
0
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV.** day **18**
 year **1940** hour **5** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Nov 16**
 _____, 19**40**, to **Nov 18**, 19**40**
 that I last saw her alive on **Nov 18**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion 2 days**

Due to **Arteriosclerosis**

Due to _____

Other conditions **HTA**
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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?
451
(Specify type of place)
 While at work? _____ Means of injury _____

28. Signature **[Signature]** (M. D. or other) **MD**
 Address **Marceline Mo** Date signed **11/22/40**

3. (a) PRINT FULL NAME **ELLA JANE CARSON**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **HENRY CARSON** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **MAY 4 1864**
(Month) (Day) (Year)

8. AGE: Years **76** Months **6** Days **14** If less than one day _____ hr. _____ min.

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

10. Usual occupation **HOUSEWIFE**

11. Industry or business **Rooming house**

12. Name **MARTIN SHERER**

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

14. Maiden name **CHRISTEEN PENCE**

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

16. (a) Informant's own signature **[Signature]**

(b) Address **4723 Calif. Omaha, Neb.**

17. (a) **BURIAL** (b) Date thereof **Nov 20 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT O Leuit**

18. (a) Signature of funeral director **Gas McLaughlin**

(b) Address **Marceline Mo**

19. (a) **11-20-40** (b) **Oliver Barrett**
(Date received local registrar) (Registrar's signature)

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 *Blanche M. Taughble*
Licensed Embalmer No. *1909*
P. O. Address *Marceline*

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.