

1. PLACE OF DEATH:  
 (a) County Butler  
 (b) City or town Carrollton  
 (c) Name of hospital or institution: Kaplar Bluff Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 hrs.  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Ark. (b) County Clay  
 (c) City or town Carrollton  
 (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.? 2 years

3. (a) PRINT FULL NAME William Albert Elder  
 (b) If veteran, name war No. (c) Social Security No. \_\_\_\_\_  
 4. Sex M 5. Color or race W  
 6. (b) Name of husband or wife Susie Elder  
 6. (c) Age of husband or wife if alive 34 years  
 7. Birth date of deceased Nov. 17 1898  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Nov day 9  
 year 1941 hour 6:30 minute 0 P. M.  
 21. I hereby certify that I attended the deceased from 11-9-41 1941, to 11-9-41 1941,  
 that I last saw him alive on 11-9-41 1941,  
 and that death occurred on the date and hour stated above

8. AGE: Years 42 Months 11 Days 22  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Hemorrhage shock & concussion of brain  
 Due to Injury caused by train striking the amputating right leg  
 Due to leg

9. Birthplace Rose Hill Ill.  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Farming  
 11. Industry or business \_\_\_\_\_  
 12. Name John Elder  
 13. Birthplace Rose Hill Ill.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Janet Smith  
 15. Birthplace Rose Hill Ill.  
 (City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 5 months of death) \_\_\_\_\_  
 Major findings: same 169-4  
 Of operations same 30  
 Of autopsy same  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Bearl Elder  
 (b) Address Carrollton Ark.  
 17. (a) Burial (b) Date thereof 11-11-41  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Carrollton Ark.  
 18. (a) Signature of funeral director Black's Mortuary  
 (b) Address Carrollton Ark.  
 19. (a) 11-14-41 (b) Belle Turner  
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) accident  
 (b) Date of occurrence 11-9-41  
 (c) Where did injury occur? near Carrollton Ark 13<sup>th</sup>  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public place right of way near RR  
 While at work? no (Specify type of place) (Specify type of place)  
 Means of injury leg  
 23. Signature Wm. Searcher (M. D. or other) \_\_\_\_\_  
 Address Kaplar Bluff Ark Date signed 11-9-41

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.

RECEIVED

Local Health Office No. 2,

District File Number 1141-1575

Date Filed 1/24/41

FEB 17 1955

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**