

1. PLACE OF DEATH

(a) County Carroll
 (b) City or town Carrollton, Mo.
 (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 Carroll L. Payne
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Gas. W. Payne 6. (c) Age of husband or wife if alive _____ years
 Birth date of deceased Oct. 4 1893 (Month) (Day) (Year)

8. AGE: Years 48 Months 1 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Gas. W. Gilbert
 13. Birthplace Mo. D (City, town, or county) (State or foreign country)
 14. Maiden name Anna E. Eggeason
 15. Birthplace Mo. D (City, town, or county) (State or foreign country)

16. (a) Informant Gas. W. Payne
 (b) Address Quincy Ill

17. (a) Burial (b) Date thereof 11-12-41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caffill Cem

18. (a) Signature of funeral director Handley
 (b) Address Carrollton, Mo.

19. (a) 11-12-41 (b) Paul Hostatus (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
 (c) City or town Quincy (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 10th
 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Nov. 10 1941 to Nov 10 1941
 that I last saw him alive on Nov 10, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 2 yrs

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 94a

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) _____
 (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 Dr. H. P. Lat (M. D. or other) _____
 Address Carrollton Mo. Date signed 11-12-41

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

NOV 27 1941

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, N.C.

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.