

FILED NOV 11 1942

Registration District No. 33

Primary Registration District No. 30.11

Registrar's No. 124

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

1. PLACE OF DEATH:  
(a) County Carroll  
(b) City or town Carrollton  
(c) Name of hospital or institution Arwood Hospital  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Carroll  
(c) City or town Carrollton Mo  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Gale Newman  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 5<sup>th</sup> year 1942 hour 10 minute 40<sup>0</sup> M.  
21. I hereby certify that I attended the deceased from Oct 5<sup>th</sup> 1942 to Oct 5<sup>th</sup> 1942, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race White 6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 5<sup>th</sup> 1942  
(Month) (Day) (Year)

Immediate cause of death Premature Birth  
Duration \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 14 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 159

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name Robt Newman  
13. Birthplace Carroll Co (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
14. Maiden name Leona Gustin  
15. Birthplace Carroll Co (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Robt Newman  
(b) Address Carrollton Mo

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? \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof 10-6-1942  
(Burial, or \_\_\_\_\_) (Month) (Day) (Year)  
(c) Place: burial or cremation Howell Cem  
18. (a) Signature of funeral director Gandley  
(b) Address Carrollton Mo  
19. (a) 10-6-1942 (b) Mrs James Rafferty  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature William B. Atwood (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 10/8/42

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 11-10-42

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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 \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

*Not Embalmed*

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, fact should be so stated above.**