DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38079

FILED DEC 7 1943

Registration District No. 83 Primary Registration District No. 5315 Registrar's No.

1. PLACE OF DEATH:
(a) County Cooper
(b) City or town Overton, Saline Township.
(If outside city or town limits, write "RURAL" and name of township)
(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 ---
In this community 40 Years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 27
(a) State Missouri (b) County Cooper
(c) City or town Overton, Saline Township
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ---

3. (a) PRINT FULL NAME William Karm.
3. (b) If veteran, name war ---
3. (c) Social Security No. ---
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mary Karm.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 28" (Day) 1865 (Year)

8. AGE: Years 78 Months 3 Days 17 If less than one day hr. min.

9. Birthplace Newalsawac India 7
(City, town, or county) (State or foreign country)
10. Usual occupation Retired R.R.Agent.
11. Industry or business Mo. Pac. R.R.Co.
FATHER
12. Name Unknown. 9
13. Birthplace " (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown.
15. Birthplace " 9 (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Carl Fischer.
(b) Address Overton, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17"/43 (Month) (Day) (Year)
(c) Place: burial or cremation Walnut Grove Cem.
18. (a) Signature of funeral director Goodman & Holler
(b) Address Boonville, Mo.
19. (a) Nov 18, 1943 (Date received local registrar) (b) Mrs N. L. Kruszer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14" year 1943 hour 12 minute Noon M.
21. I hereby certify that I attended the deceased from Oct 14, 1943, to Nov. 14, 1943, that I last saw him alive on Nov 3, 1943, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of thyroid. Causing strangulation	6 months
Due to Compression of trachea	
Due to	
Other conditions fractured right hip (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

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 027
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [illegible] (M. D. or other)
Address Boonville, Mo. Date signed Nov 16 1943

1137

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12-6-43

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 G. F. Bolles

Licensed Embalmer No. 3067

P. O. Address Boonville, N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
1—5-43
I X36930

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BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 83 Primary Registration District No. 5315 Registrar's No.

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Salvia Twp.
(If outside city or town limits, write "RURAL" and name of township)

(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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

3. (a) PRINT FULL NAME William Karn

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 28 (Day) 1865 (Year)

8. AGE: Years 78 Months 2 Days 17 If less than one day hr. min.

9. Birthplace (City, town, or county) India (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1 4
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Thyroid

Due to causing strangulation
stric

Due to congestion of trachea

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations fractured right hip
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?
fell from outside porch at home
(Specify type of place)
While at work? (e) Means of injury at Overton, Mo
Nov 7. 1943

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PER

38019