

FILED FEB 8 1944

Registration District No. _____

Primary Registration District No. 5318

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Cooper
(b) City or town Rural Lebanon Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community all of life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cooper
(c) City or town Rural Lebanon Mo
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10
year 1944 hour 6 minute 30 P M.

21. I hereby certify that I attended the deceased from Dec 20
1943 to Jan 10 1944
that I last saw him alive on Dec 20 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral volume heart disease
Duration 5 yrs

Due to _____
Due to _____

Other conditions 92d
(Include pregnancy within 3 months of death)

Major findings: 92d
Of operations _____
Of autopsy _____

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 [Signature] (M. D. or other) MD
Address [Address] Date dictated 1/7/44

3. (a) PRINT FULL NAME MIKE CARROLL

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 single

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

7. Birth date of deceased 7 15 1861
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>6</u>		hr. _____ min.

9. Birthplace Morgan County - Mo
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name Patrick Carroll

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

14. Maiden name Ellen Eagon

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

16. (a) Informant Willie Carroll

(b) Address Cherryville Mo

17. (a) Home Lebanon (b) Date thereof 1 17 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director [Signature]

(b) Address Cherryville Mo

19. (a) Jan 19-1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

X26390

RECEIVED

District Health Officer No. 4

District File Number

Date Filed

2-20-44

MAY 4 1945

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.....

my self

working under my personal supervision.

....., Registered Apprentice No.

Signed.....

L. H. Parkinson

..... Licensed Embalmer No.

5547

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.