

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 7 1945

Registration District No. 139

Primary Registration District No. 4775

Registrar's No. 38

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

1. PLACE OF DEATH:

(a) County Holt
(b) City or town Oregon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Brown's Nursing Home
(If not in hospital or institution, write street number or location) 11
(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 Holt
(c) City or town Oregon
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles Carson

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

7. Birth date of deceased June 9, 1958
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 0 20 hr. min.

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

10. Usual occupation Farm Laborer

11. Industry or business _____

12. Name Unknown 9

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

14. Maiden name Unknown 9

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

16. (a) Informant Mrs. Lora Brian

(b) Address Oregon Mo

17. (a) Burial (b) Date thereof 6-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oregon, Mo

18. (a) Signature of funeral director James P. Pettigosh

(b) Address Oregon Mo

19. (a) 6-30-45 (b) Pauline Dawson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
year 1945 hour 2 A.M. minute 13 M.

21. I hereby certify that I attended the deceased from June 14
1940 to June 28, 1945

that I last saw him alive on June 13, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Interstitial Nephritis 2 yrs

Due to June 28, 1945

Due to Gripped from broken hip.
about one year

Other conditions _____
(Include pregnancy within 3 months)

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of operations _____
Of autopsy None

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? Brown's Nursing Home
(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 John P. Chandler (M. D. or other) _____
Address Oregon Mo. Date signed 6-28-45

1185

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 James H. Pettyjohn
Licensed Embalmer No. 3192
P. O. Address Oregon Mo.

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.