

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
604 E Washington
(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 Mo (b) County Carroll
(c) City or town Carrollton
(If outside city or town limits, write "RURAL")
(d) Street No. 604 E Washington
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME JOHN R. CASELDINE
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2
year 1945 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from Aug 1, 1945 to Aug 1, 1945
that I last saw him alive on Aug 1, 1945
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
(b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
alive _____ years
7. Birth date of deceased Dec 13 1959
(Month) (Day) (Year)

Immediate cause of death uremia
poison
Due to old age. never saw
Due to the man but once.

8. AGE: Years 85 Months 7 Days 20 If less than one day _____ hr. _____ min.

Other conditions _____
(Include pregnancy within 3 months of death)

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

10. Usual occupation Retired

11. Industry or business Farming

12. Name John Caseldine

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

14. Maiden name Louise Alford

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

16. (a) Informant Mrs Minnie Warner

(b) Address Norborne, Mo.

17. (a) Burial (b) Date thereof 8-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Low Gap Cem

18. (a) Signature of funeral director John Deitch

(b) Address Norborne, Mo.

19. (a) 8-21-45 (b) Mrs James Ruffly
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations _____
Of autopsy 127

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) (s) Means of injury _____

23. Signature R. Hamilton (M. D. or other) M.D.

Address Carrollton, Mo. Date signed 8/21/45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

9-7-45 ✓

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

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.