

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 20 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4261**  
Registrar's No. **167**

Registration District No. **55**

Primary Registration District No. **5190**

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

**1. PLACE OF DEATH:**

(a) County Carroll

(b) City or town Rural, Carrollton, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community entire life (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Carroll

(c) City or town Rural  
(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** LOUELLA T. BOWLES

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 30  
year 1947 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1-2-  
1949, to 1-27 1949.

I last saw her alive on 1-27-49  
and that death occurred on the date and hour stated above.

4. Sex Fe 1. Color or race W

5. Color or race W

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

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

7. Birth date of deceased: Aug 20 1862  
(Month) (Day) (Year)

Immediate cause of death Chronic nephritis

Duration 3

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings, Of operations: 131B

Of autopsy \_\_\_\_\_

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

**8. AGE:**

Years	Months	Days	If less than one day
<u>84</u>	<u>5</u>	<u>10</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Martin A. Trotter

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

14. Maiden name Luene Sherwood

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

MOTHER FATHER

16. (a) Informant Ralph Bowles

(b) Address Carrollton Mo

17. (a) Burial (b) Date thereof 2-2-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beatty Cem

18. (a) Signature of funeral director Stanley Gibson

(b) Address Carrollton Mo

19. (a) 1/31/47 (b) Mr. Herbert Calvert  
(Date received local registrar) (Registrar's signature)

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 0

23. Signature W.S. Atwood (M. D. or other)  
Address Carrollton, Mo Date signed 1/31/47

RECEIVED

District Health Officer No. 8,

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

Date Filed 2-17-47

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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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton Mo

**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.