No. 2
—5-43
5-17-39
X38671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 13 1947

Registration District No. 55

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16809

Primary Registration District No. 30 11

Registrar's No. 201

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: 708 E. Heidle
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 11 years (Specify whether years, months or days)
In this community:

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.: 708 E. Heidle
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: LOUELLA TEETER

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Fe.

5. Color or race: W.

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Wm. E. Teeter

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

7. Birth date of deceased: Dec. (Month) 1 (Day) 1891 (Year)

8. AGE: Years 55 | Months 5 | Days 27 | If less than one day: hr. min.

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

10. Usual occupation: At Home

11. Industry or business:

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

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

16. (a) Informant: Wm. E. Teeter
(b) Address: Carrollton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/31/1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Wharton Cem.

18. (a) Signature of funeral director: Standley & Gibson
(b) Address: Carrollton, Mo.

19. (a) 5/29/47 (Date received local registrar) (b) Mrs Herbert Calvert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 28
year: 1947 hour: 11 minute: 45 P. M.

21. I hereby certify that I attended the deceased from June 1, 1946 to May 28, 1947 that I last saw her alive on May 28, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of female organs — Duration: 3 yrs.

Due to:

Due to:

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

Major findings:
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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: R. Hamilton Staton (M. D. or other)
Address: Carrollton, Mo. Date signed: May 29, 1947

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 6-12-47

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.....

Licensed Embalmer No.....

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.

. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 24

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:
(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 Louella Teeter

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 1 (Month) 1891 (Day) (Year)

8. AGE: Years 55 Months 5 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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 Mar 28
year 1947 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	Duration
Uterus	?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

48 PB

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature R. Hamilton Stakes M.D. (M.D. or other)
Address Date signed

SUPPLEMENTARY

S-16809