

Registration District No. **97** Primary Registration District No. **4154**

1. PLACE OF DEATH:
 (a) County **DADE**
 (b) City or town **GREENFIELD**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
SEYBERT ROAD
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **one month**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **CALIFORNIA** (b) County **LOS ANGELES**
 (c) City or town **LOS ANGELES**
(If outside city or town limits, write "RURAL")
 (d) Street No. **611 East 5th Street**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **No**

3. (a) PRINT FULL NAME **CHARLES B. CARROLL**
 (b) If veteran, name war **No**
 (c) Social Security No. **None**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **June** day **23**
 year **1947** hour **8** minute **15 P.** M.
 21. I hereby certify that I attended the deceased from **June 20**
 1947, to **June 23**, 1947

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Single**
 (b) Name of husband or wife **None**
 (c) Age of husband or wife if alive **29** years
 (Day) (Year)

that I last saw him alive on **June 23**, 1947
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Cerebral Hemorrhage**

8. AGE:	Years	Months	Days	If less than one day
	76	6	25	hr. min.

Due to
 Due to
 Other conditions (include pregnancy within 3 months of death)

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **N. A. Carroll**

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

14. Maiden name **Edith Ann Fields**

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

16. (a) Informant **Miss Minnie Carroll**
 (b) Address **Greenfield, Mo.**

17. (a) **Burial** (b) Date thereof **6-25-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenfield Cemetery**

18. (a) Signature of funeral director **Sam E. Senevey Jr**
 (b) Address **Greenfield, Mo.**

19. (a) **6-20-47** (b) **Geo. H. Weir Jr**
(Date received local registrar) (Registrar's signature)

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?
 While at work? (Specify type of place)
 (e) Means of injury
 23. Signature **Dr. J. H. Jones** M. D. or other
 Address **Greenfield, Mo.** Date signed **6/23/47**

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

29
 1
 0

RECEIVED

RECEIVED

District Health Officer No. 6,

District File Number 747-699

Date Filed JUN 17 1947

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 Sam E. Senevey Jr

Licensed Embalmer No. 4099

P. O. Address Greenfield, 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.