

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

9856

**1. PLACE OF DEATH**

County Carroll  
Township Carroll  
City Carrollton (No. ....)

Registration District No. 135  
Primary Registration District No. 3034

File No. ....  
Registered No. 22  
St. .... Ward

**2. FULL NAME** Froter Cary

(a) Residence No. .... St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lena Strand Cary

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 20 - 1858  
7. AGE YEARS MONTHS DAY IF LESS than 1 day, hrs. or min. 70 | 2 | 15

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carroll Co.

10. NAME OF FATHER Henry Cary

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER Mary Ann Trotter

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Carroll Co.

14. INFORMANT (Address) J. R. Cary  
Carrollton Mo.

15. FILED 3-6, 1929 ms E E Farnham  
REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-5 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-1-29, 1929, to 3-5, 1929 that I last saw h. live alive on 3-1, 1929 and that death occurred, on the date stated above, at 10 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral hemorrhage

CONTRIBUTORY (SECONDARY) Chr? interstitial nephritis  
(duration) 3 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? 129 W  
IS NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none  
(Signed) J. B. Brown, M. D.  
3-6, 1929 (Address) Carrollton Mo

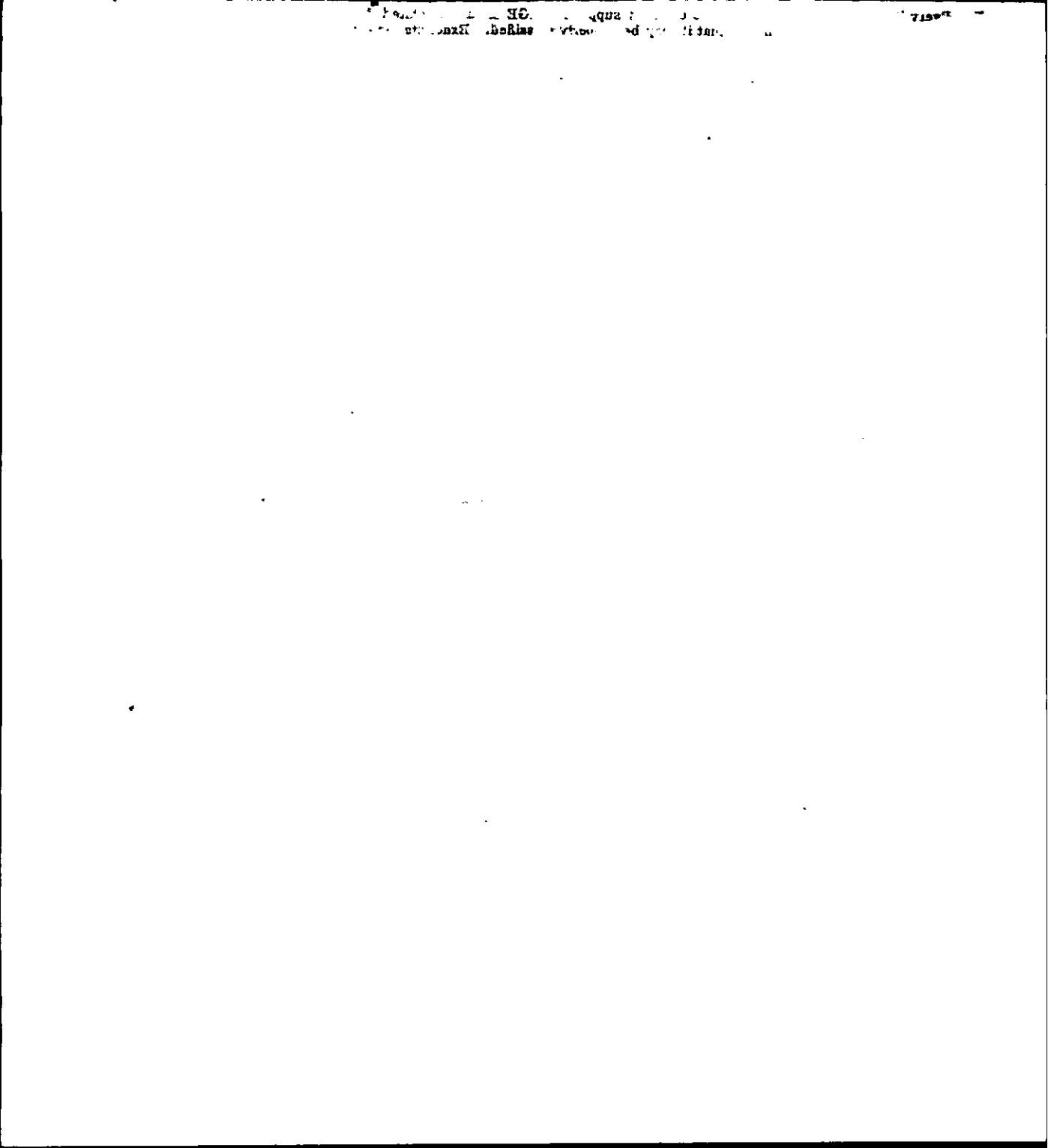
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Hill DATE OF BURIAL 3-7 1929

20. UNDERTAKER Standley Carrollton Mo  
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

17  
24 1929  
3  
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**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

7856  
ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Carroll

Registration District No. 133

File No. ....

Township .....

Primary Registration District No. 3031

Registered No. 22

City Carrollton (No. ....)

St. .... Ward)

**2. FULL NAME**

Frotter Cary

(a) Residence. No. S ..... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT .....  
(Address)

15.

FILED 3-6 1929 Mrs G.E. Jamison  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-5-1929

17.

I HEREBY CERTIFY That I attended deceased from .....

19....., 19....., and that that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D  
, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be supplied. AS EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-9856