

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

32106
Do not use this space.

DEC'D OCT 27 1939

1. PLACE OF DEATH

(a) County Carroll Registration District No. 135
(b) Township Carroll Primary Registration District No. 5188
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
352 M Mildred Beulah Withers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unwed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sam Withers
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 30, 1875
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 2 19
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carroll Co Mo

FATHER 13. NAME Walter O. Squires
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Francis Hancock
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) E. B. Withers
Carrollton, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Pleasant Park DATE Sept 31, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stanley
Carrollton, Mo.

20. FILED 9-21 1939 Withers Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from 7-1, 1930, to 9-19, 1939
I last saw he alive on 9-18, 1939 Death is said to have occurred on the date stated above, at 10 m.
The principal cause of death and related causes of importance were as follows:

Chronic Pulmonary Tuberculosis Date of onset 1920

Other contributory causes of importance: 22

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) H. B. Decon, M. D.
(Address) Carrollton, Mo

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10/9/39

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,

Ben W Gibson

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

Ben W Gibson

Licensed Embalmer No.

2961

P. O. Address

Carroleton, Va

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, above space should be left blank.