DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 1 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24954

Registration District No. 213 — Primary Registration District No. 3014 — Registrar's No. 182

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

1. PLACE OF DEATH:

(a) County Cole

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

(c) Name of hospital or institution: St Marys Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Eight Days (Specify whether)

In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole

(c) City or town Centertown Mo (If outside city or town limits, write "RURAL")

(d) Street No. ____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Carrie C. Royce

3. (b) If veteran, name war —

3. (c) Social Security No. ____

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Charles W Royce

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Sept (Month) 16 (Day) 1886 (Year)

8. AGE: Years 53 | Months 10 | Days 4 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business ____

FATHER
12. Name Wm A Anderson
13. Birthplace ____ (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Nancy E Litteson
15. Birthplace Centertown (City, town, or county) Mo (State or foreign country)

16. (a) Informant Charles W Royce Husband
(b) Address Centertown Mo

17. (a) Centertown Mo (Burial, cremation, or removal) (b) Date thereof July 22 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Centertown Mo

18. (a) Signature of funeral director W C Tapp
(b) Address 700 Jefferson St Jeff City Mo

19. (a) 7/24/40 (Date received by local registrar) (b) M Bedford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 22 day 20
year 1940 hour 7 minute ____ M.

21. I hereby certify that I attended the deceased from June 15, 1940 to July, 1940 that I last saw her alive on July, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypertension	
Nephritis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations ____
Of autopsy ____

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 M Bedford (M. D.)
Address Jr C Mo Date signed 7/24/40

(Licensed Embalmer's Statement on Reverse Side)

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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 Tom H. Waggoner

Licensed Embalmer No. 3303

P. O. Address Jefferson City, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

DEPARTMENT OF COMMERCE
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STANDARD CERTIFICATE OF DEATH

State File No. 24954

Registration District No. 913 Primary Registration District No. 3014 Registrar's No.

1. PLACE OF DEATH:
(a) County Cole
(b) City or town Jefferson city
(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 years, months or days)
In this community

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) If foreign born, how long in U. S. A.? years.

3. (a) PRINTED FULL NAME Carrie C. Royse
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 (Month) (Day) (Year)

8. AGE: Years 53 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace (City, town, or county) (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) 9/24/40 (Date received by local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1940 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.

	Duration
Immediate cause of death Hypertension	
Due to nephritis, chronic	
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, public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature S. D. Bedford (M. D. or other)
Address Jefferson City Date signed

SUPPLEMENTARY

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