

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14076**
Registrar's No. **25**

LED MAY 8 1943
Registration District No. **3015**

Primary Registration District No. **3015**

1. PLACE OF DEATH:

(a) County **Clinton**
(b) City or town **Cameron**
(c) Name of hospital or institution: **xxx /**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **xxx** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clinton**
(c) City or town **Cameron**
(d) Street No. **628 East 2nd,**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **XXXXX**

3. (a) PRINT FULL NAME

NANCY E TARTER

3. (b) If veteran, name war **no**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **E. J. D. Tarter**
6. (c) Age of husband or wife if alive **79** years
7. Birth date of deceased **March 6 1869**

8. AGE: Years **74** Months **0** Days **16**
If less than one day **hr. min.**

9. Birthplace **Dekalb Co. Mo.**

10. Usual occupation **Housework**

11. Industry or Business **in Home**

MOTHER FATHER { 12. Name **Jacob Dice**
13. Birthplace **XXXXXXXXX Germany**
14. Maiden name **Anna Belk.**
15. Birthplace **XXXXXX Ky**

16. (a) Informant **Oliver Weiss**
(b) Address **Cameron, Mo.**

17. (a) **Burial** (b) Date thereof **April 4, 1943**
(c) Place: burial or cremation **Christian Chapel, Dekalb Co. Mo.**

18. (a) Signature of funeral director **[Signature]**
(b) Address **Cameron, Mo.**

19. (a) **Apr. 2, 1943** (b) **Mrs. Kathleen Harris**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **31st**
year **1943** hour **5** minute **20** **A.M.**

21. I hereby certify that I attended the deceased from **3-24-1943** to **3-31-1943**
that I last saw her alive on **3-31-1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis** **3-24-1943**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **[Signature]**
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)

23. Signature **[Signature]** (M. D. or other) **[Signature]**
Address **Cameron, Mo.** Date signed **4-2-43**

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

State of Ill.

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 _____
C. Moore

Licensed Embalmer No. *1180*

P. O. Address *Cameron, 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.