JUN 1 1927

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

Do not use this space.

13832

1. PLACE OF DEATH

County: Saline
Township: ~~Marshall~~
City: Marshall (No. ..... St. ..... Ward)

Registration District No. 796
Primary Registration District No. 3038

File No. .....
Registered No. 50

2. FULL NAME John Robert McCarter

(a) Residence. No. ..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 28, 1927

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
			8	

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

9. BIRTHPLACE (CITY OR TOWN) Marshall
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER O. W. McCarter
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lee Summit
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Mary Francis Killion
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Corder
(STATE OR COUNTRY) Mo.

14. INFORMANT Mr. O. W. McCarter
(Address) Marshall, Mo.

15. FILED 4/6, 1927 D. F. Manning REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 5 1927

17. I HEREBY CERTIFY, That I attended deceased from Mch. 28, 1927, to Apr. 5, 1927 that I last saw him alive on Apr. 5, 1927, and that death occurred, on the date stated above, at 4:00 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature baby -
Defective digestive system -
159
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) 16/A
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) [signature], M. D.
4-5, 1927 (Address) Marshall, 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: Corder Mo.
DATE OF BURIAL: Apr. 6 1927

20. UNDERTAKER: Vandiver-Leist
ADDRESS: Marshall ~~Corder Mo.~~ Mo.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important. Spelling in plain terms, so that it may be properly classified.

1. PLACE OF DEATH

County: Saline — Registration District No.: 796 — File No.:

Township: — Primary Registration District No.: 3038 — Registered No.: 50

City: Marshall (No. ..., ..., St. ..., Ward)

2. FULL NAME John Robert McCarter

(a) Residence No. ... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 6/15, 1927 D. H. Manning, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 5 1927

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ...m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

...
...
... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) ...
... (duration) ... yrs. ... mos. ... ds.

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 Apr 6 1927

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

S-13832