

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

Do not use this space.  
13614

1929

1. PLACE OF DEATH  
 County Verona Registration District No. 875  
 Township W. Washington Primary Registration District No. 6162  
 City Webb (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 File No. \_\_\_\_\_  
 Registered No. 84

2. FULL NAME Thomas A. Carter Centerview, Mo.  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward Warrensburg, Mo.  
 (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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>68</u>	<u>3</u>	<u>13</u>		

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) Ky.  
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm. Carter

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

12. MAIDEN NAME OF MOTHER Wm. Wm. Carter

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

14. INFORMANT Mrs. T. A. Carter  
 (Address) \_\_\_\_\_

15. FILED 4/30 1929 E. R. King  
 REGISTRAR

**4 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 20<sup>th</sup> 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15<sup>th</sup> 1929, to Nov. 20<sup>th</sup> 1929.  
 that I last saw him alive on Nov. 20<sup>th</sup> 1929, and that death occurred, on the date stated above, at 1:30 p. m.

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

Influenza and complications of pneumonia - fracture of fore  
 (duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) Senile dementia  
Myocarditis (duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

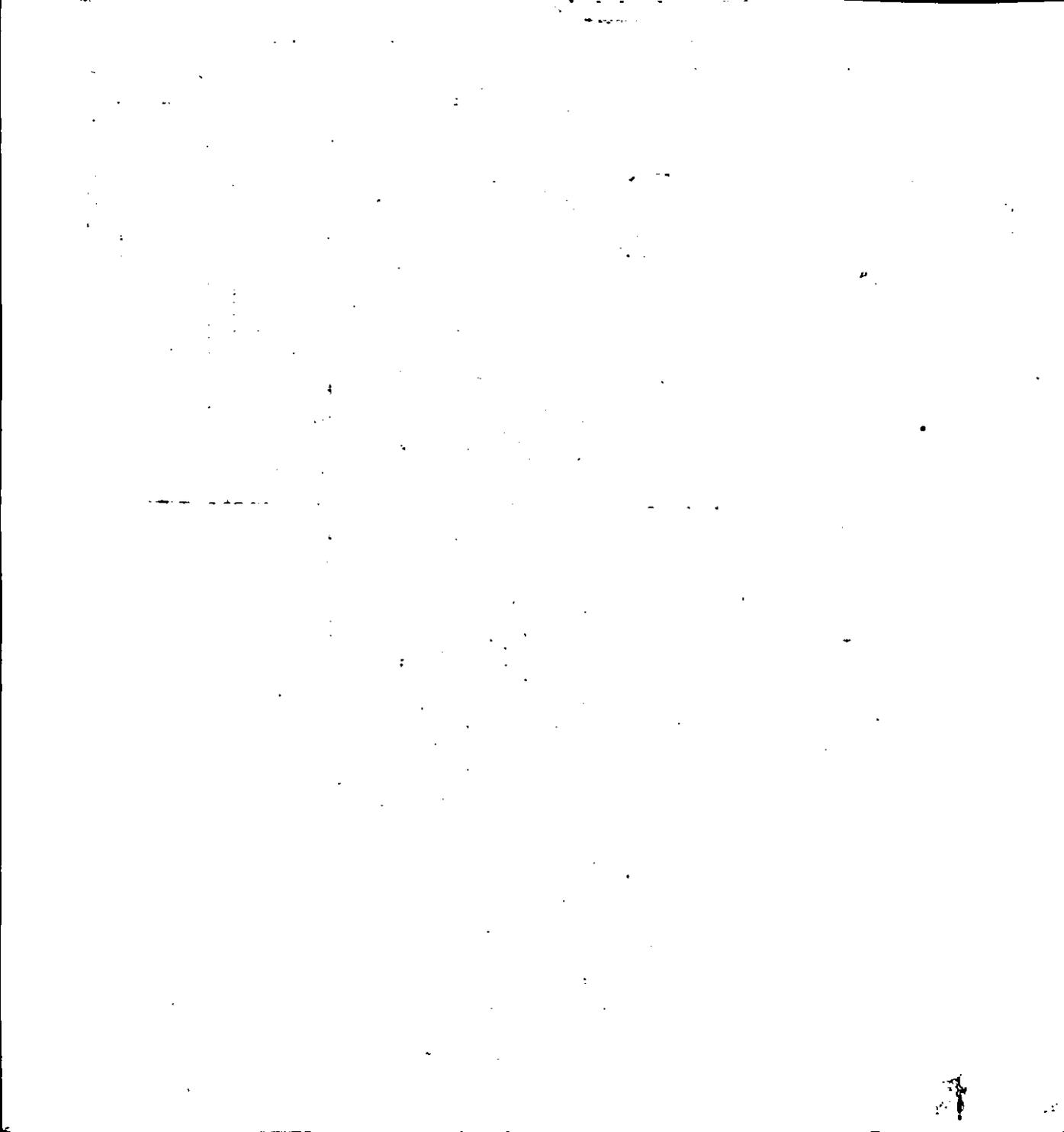
WHAT TEST CONFIRMED DIAGNOSIS? description of test  
 (Signed) Scott P. Child M. D.  
Mar. 20 1929 (Address) State Hospital #3, Nevada, Mo.

\*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 Adessa Mo DATE OF BURIAL Mar 21 1929

20. UNDERTAKER Allen V. Lays Nevada Mo ADDRESS \_\_\_\_\_

1  
2  
2  
31



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Vernon Registration District No. 875- File No. \_\_\_\_\_  
 Township Washington Primary Registration District No. 6162 Registered No. 84  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Thomas A. Carter

(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 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) Nov. 7<sup>th</sup>, 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>68</u>		<u>3</u>	<u>13</u>	

**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.....  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

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 4/20-29. E. R. Rising REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 20 1929

17. I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ since on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

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

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-13614