JUN 25 1929

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

Do not use this space.

17711

1. PLACE OF DEATH

County Dekalb — Registration District No. 239

Township ——— — Primary Registration District No. 4158

City Maysville (No. ——— ——— St. ——— Ward)

File No. ———

Registered No. ———

2. FULL NAME Malinda 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Fem.	wh.	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: Wesley p. Carter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 5th 1850

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ——— hrs. or ——— min.
	78	5	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(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) Mo.

PARENTS

10. NAME OF FATHER do not know

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

12. MAIDEN NAME OF MOTHER Lydia Deppen

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

14. INFORMANT Mrs L. Carter Roach
(Address) Maysville.

15. FILED 5/13, 1929 J. L. Phelps REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12th. 1929

17. I HEREBY CERTIFY, That I attended deceased from December 10th, 1928, to May 12th, 1929, that I last saw h.er alive on May 12th, 1929, and that death occurred, on the date stated above, at 11-40 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterial Sclerosis

17

General yrs. (duration) ——— yrs. ——— mos. ——— ds.

CONTRIBUTORY (SECONDARY) ———

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

18. WHERE WAS DISEASE CONTRACTED? at her home

IF NOT AT PLACE OF DEATH. ———

DID AN OPERATION PRECEDE DEATH? No. DATE OF ———

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms

(Signed) John M Brown, M. D

——— , 19 (Address) Maysville 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: Amity Mo.

DATE OF BURIAL: 5/14 1929

20. UNDERTAKER: U? G. Pilcher

ADDRESS: Maysville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE FUNERAL WITH BURIAL PERMIT—THIS IS A PERMANENT RECORD