

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

Do not use this space.

36574

File No. 120
Registered No.

1. PLACE OF DEATH

County Carroll Registration District No. 135-
Township Carrollton Primary Registration District No. 3010
City Carrollton (No.) St. Ward)

2. FULL NAME

Hatter 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. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 W. T. Carter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24 - 1861

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,	
				hrs.	min.
	<u>68</u>	<u>2</u>	<u>19</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Quincy, Ill.
(STATE OR COUNTRY)

10. NAME OF FATHER Geo. Moffett

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

12. MAIDEN NAME OF MOTHER Lynch

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

14. INFORMANT Mrs W. T. Carter
(Address) Boyard, Mo.

15. FILED 11-15-29 Mrs E. E. Farham
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 13 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1929, to Nov. 13 6:30 that I last saw her alive on Nov 13 1929, and that death occurred, on the date stated above, at 8:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Spleen
53 E
54 B

(duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) Fibroid uterus
(duration) 2 yrs. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS Physical Exam.

(Signed) J. M. Woodson, M. D.

11/15 1929 (Address) Boyard 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

DATE OF BURIAL

Mt Zion

11/15 1929

20. UNDERTAKER

ADDRESS

E. E. Decker

Boyard Mo.

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.

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