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.

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

Do not use this space.

3099

1. PLACE OF DEATH

County ..... Registration District No. 791 ..... File No. .....

Township ..... Primary Registration District No. 1003 ..... Registered No. 589

City St. Louis, Mo. (No. 1703 Wash St. ..... St. ..... Ward)

2. FULL NAME Joshua Cartee

(a) Residence. No. 1703 Wash St St., 25 Ward. Doe Run 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 15 - 1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	54	5	0	

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) St. Francis County
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Joseph Cartee

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Francis Co.
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Sarah Thompson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Francis Co.
(STATE OR COUNTRY) Mo.

14. INFORMANT John Cartee
(Address) Doe Run, Mo

15. FILED JAN 18 1930 19 Max C Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 15 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw h..... alive on ..... 4 00 ..... 19 P, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

W M (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

No Physician attending (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? No.

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Jim Hurley, M.D.

1/18 1930 (Address) DeFiley Co. 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 Pendleton Cemetery Doe Run, Mo

DATE OF BURIAL 1/20/1930

20. UNDERTAKER John Neidert

ADDRESS Doe Run, Mo