

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

Do not use this space.

39630

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Keokuk Primary Registration District No. _____
 City Kansas City (No. Kansas City General Hosp) Ward _____

File No. _____
 Registered No. 5204

2. FULL NAME

James Carter
 (a) Residence. No. 6819 1/2 Summer Road Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 4 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Married

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18, 1909

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
21 5 7

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Unknown
 (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) Kentucky

10. NAME OF FATHER Wm. Carter
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 12. MAIDEN NAME OF MOTHER Sarah Beckler
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

14. INFORMANT (Address) Dora Clark
K.C. General Hosp

15. FILED 12/29/30 M. M. Crowe
 asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-25 1930

17. I HEREBY CERTIFY, That I attended deceased from 11-20, 1930 to 12-25, 1930 that I last saw him alive on 12-25, 1930 and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute appendicitis
12 1/8
129
110A (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Peritonitis and Embryoma (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH _____

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____
 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) P. E. Wilcox, M. D.
12-26, 1930 (Address) Em Hopt Kc 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
Somerset Kentucky Dec 30 1930

20. UNDERTAKER ADDRESS
John J. Sheehan K.C. Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1930
21
09

144