

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

Do not use this space.

13692

**1. PLACE OF DEATH**

County Douglas  
Township Washington  
City Washington (No.         )

Registration District No. 281  
Primary Registration District No. 3400

File No.           
Registered No.           
St.          Ward         

**2. FULL NAME**

(a) Residence. No.          St.          Ward           
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**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         

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 1st 1931

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

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) None  
(c) Name of employer         

9. BIRTHPLACE (CITY OR TOWN) Douglas Co, Mo  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Albert Carter  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Julia May Collins  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Illinois  
(STATE OR COUNTRY)

14. INFORMANT Father  
(Address)         

15. FILED 4-25-31 G. D. Hale REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 14, 1931

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1931, to April 21, 1931, and that I last saw him alive on April 21, 1931, and that death occurred, on the date stated above, at 8 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Marasmus  
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) Dysentery  
(duration) yrs. mos. 3 ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF           
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? Physical & Dysentery  
(Signed) M. C. Gentry, M. D.  
4-20, 1931 (Address) W. C. W.

\*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 4-22, 1931

20. UNDERTAKER Neighbors ADDRESS         

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.

May 23 1931

CAUSE OF DEATH in plain terms, so the  
M.B.—Every item of information should be

AGE should be

17777

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

4/31  
 ALL INFORMATION CALLED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Douglas  
 Township Washington  
 City                      (No.                     )

Registration District No. 281  
 Primary Registration District No. 3400

File No.                       
 Registered No.                       
 St.                      Ward                     

**2. FULL NAME**

John W. 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 S  
 (write the word)

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

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

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

**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

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 4-28-31 G. D. Hale  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-21-1931

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY  
 (SECONDARY) (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?                     

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 X DATE OF BURIAL 4-22-1931  
 20. UNDERTAKER Neighbors ADDRESS                     

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

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