

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

Do not use this space.

3720

1. PLACE OF DEATH

County Boone Registration District No. 71
Township Cedar Primary Registration District No. 5-110A
City (No.) _____ St. _____ Ward _____

File No. _____
Registered No. 85
St. _____ Ward _____

2. FULL NAME Daniel Sil 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mary Ellen Carter</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 28-1864</u>				
7. AGE	YEARS <u>67</u>	MONTHS <u>5</u>	DAYS <u>29</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>farmer</u> (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 2

PARENTS	10. NAME OF FATHER <u>Sandon Carter</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>
	12. MAIDEN NAME OF MOTHER <u>Elizabeth Nichols</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u> <u>1</u>

14. INFORMANT Nattie Nichols
(Address) Hartsburg, Mo.

15. FILED 2/27 1932 R. G. Nichols
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 27 1932

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1931 to Feb 24, 1932 that I last saw him alive on Feb 20, 1932 and that death occurred, on the date stated above, at 9 AM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23 (duration) 2 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 1
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) H. B. Jones, M. D.
2.27.1932 (Address) Ashland 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 <u>Int Pleasant</u>	DATE OF BURIAL <u>2/28 1932</u>
20. UNDERTAKER <u>Ashland Undert Co Ashland</u>	ADDRESS

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.



67-5-49

1864-8-28

1932-2-27

13.57

5.