

1 OCT 13 1934

MISSOURI BOARD OF HEALTH
BIOMETRIC VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH
 County Buchanan No. 85
 Township 6 Station District No. 1001
 City St. Joseph, (No. 1) Methodist Hospital St. 1046 Ward 1046

2. FULL NAME Frances Romaine Carter
 (a) Residence, No. Albany, Mo. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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) July, 13, 1934

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>0</u>	<u>1</u>	<u>27</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Entry Co. Mo.

13. NAME Wayne Carter

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Martinville, Mo.

15. MAIDEN NAME Grace Lou Rhodes

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Albany, Mo.

17. INFORMANT Wayne Carter (ADDRESS) Albany, Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Albany, Missouri DATE Sept. 11, 1934

19. UNDERTAKER (ADDRESS) Walter Meinholler, 1302 Aaron St. St. Joseph, Mo.
John R. Beardsley Registrar

4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 10, 1934 1934

22. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1934 to Sept 10, 1934
 I last saw him or alive on Sept 9, 1934 Death is said to have occurred on the date stated above, at 7.15m. A.M.
 The principal cause of death and related causes of importance were as follows:
Septicemia
Impetigo
Cellulitis of Head
 Other contributory causes of importance:
None
 Name of operation None Date of None
 What test confirmed diagnosis? None Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? None Date of injury None, 1934
 Where did injury occur? None (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
 Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify None
 (Signed) W. Roger Moore, M. D.
 (Address) Kirkpatrick Bldg., St. Joseph, Mo.

Date of onset 9-4-34
9-1-34
9-4-34

St Joseph

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Francis Bernayne Carter

Who died at _____ on Sept 10 - 1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 0 Months 1 Days 27

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) Impilego Cellulites of head

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Traumatic Infected Insect Bites

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician W R Moore

Address of physician St Joseph Mo

Signature of Registrar John C. Bledsoe Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McLaugh

State Registrar

Special Agent.

Reg. Dist. No. 85

Primary Reg. Dist. No. 1001

5-32001