

JAN 15 1936

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

Do not use this space.

38648

1. PLACE OF DEATH

County Buchanan  
Township  
City St. Joseph,

Registration District No. 85  
Primary Registration District No. 1001  
(No. St. Joseph's Hospital, St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_  
Registered No. 1317

2. FULL NAME

Barbara Joan Carpenter,

(a) Residence, No. 2310 Angelique 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. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single,</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>January 15, 1935</u>		
7. AGE YEARS <u>0</u>	MONTHS <u>11</u>	DAYS <u>1</u>
		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Child,</u>	
	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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 16th . 1935

22. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1935, to Dec 16, 1935.  
I last saw her alive on Dec 16, 1935. Death is said to have occurred on the date stated above, at 4:40 a.m.  
The principal cause of death and related causes of importance were as follows:

Cerebrospinal Meningitis Date of onset 12-15-35

Other contributory causes of importance

Name of operation None Date of \_\_\_\_\_  
What test confirmed diagnosis? Spinal Fluid Exam Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

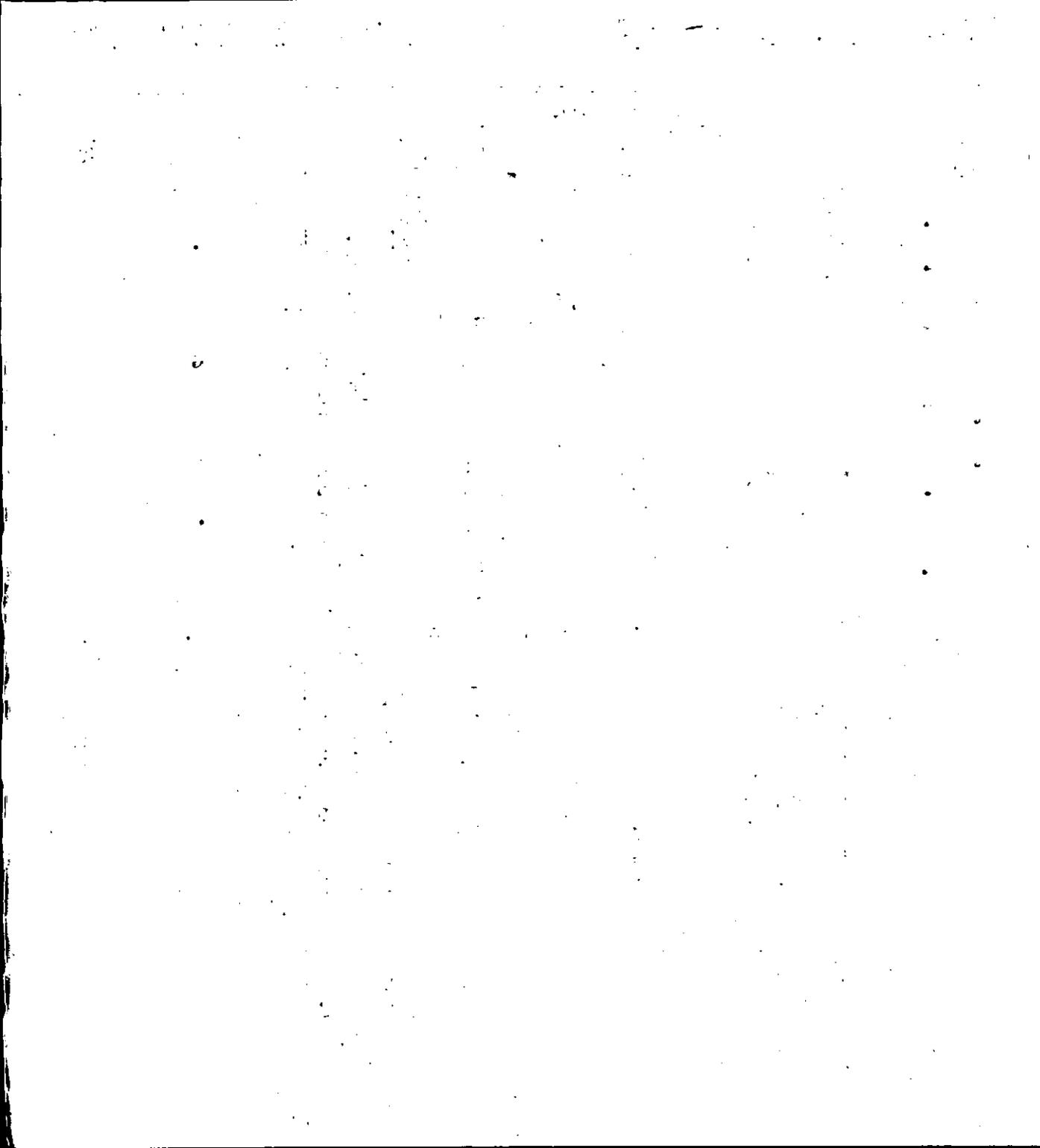
Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) W. Roger Moore, M. D.  
(Address) St. Joseph Mo

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Saint Joseph, Missouri,</u>
	13. NAME	<u>Arthur L. Carpenter,</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Rosendale, Missouri,</u>
	15. MAIDEN NAME	<u>Neva Yager,</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Skidmore, Missouri,</u>
	17. INFORMANT (ADDRESS)	<u>Arthur L. Carpenter 2310 Angelique Street,</u>
	18. BURIAL, CREMATION, OR REMOVAL PLACE	<u>St. Jo. Mem. Park DATE Dec. 17th, 1935</u>
	19. UNDERTAKER (ADDRESS)	<u>Heaton-Bellah-Bowman 319 South 10th. St. - General Home</u>
	20. FILED	<u>12-17-1935 John P. Bunker Registrar.</u>

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**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.  
Do not use this space.

**1. PLACE OF DEATH**

County Buchanan  
Township \_\_\_\_\_  
City St Joseph (No. St Joseph's Hosp)

Registration District No. 85  
Primary Registration District No. 1001

File No. \_\_\_\_\_  
Registered No. 1317 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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. 0 11 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
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) \_\_\_\_\_

MOTHER FATHER 13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 1-24 1936 John R. Bender Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 16 1935

22. I HEREBY CERTIFY, That I attended deceased from Dec 13 1935, to Dec 16 1935

I last saw h. or alive on Dec 16 1935 Death is said to have occurred on the date stated above, at 4:20a m.

The principal cause of death and related causes of importance were as follows:

Cerebrospinal Meningitis Date of onset Dec 13 -1935  
(Epidemic)

Other contributory causes of importance: 18

Name of operation Tome Date of \_\_\_\_\_  
What test confirmed diagnosis? Sturtevant's Was there an autopsy? No

23. 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 \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_

(Signed) W.P. Hoars, M. D.  
(Address) St Joseph, Mo

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.

SUPPLEMENTARY

S-38648