

SEP 26 1938

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

29400  
Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 503  
 (b) Township 1 Primary Registration District No. 4306 Registered No. 199  
 (c) City Mudville, Mo (d) Street No. \_\_\_\_\_ St.  
 (e) Length of residence in city or town where death occurred 50 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William E. Carter

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan - 5 - 1865  
 7. AGE YEARS 73 MONTHS 7 DAYS 2 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug - 7 1938  
 22. I HEREBY CERTIFY, That I attended deceased from May 15 1938, to Aug 7 1938  
 I last saw him alive on Aug 7 1938. Death is said to have occurred on the date stated above, at 3:02 a.m.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Veterinary  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

The principal cause of death and related causes of importance were as follows:  
Angina pectoris  
Pulmonary Embolism  
Smoking  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: AHK

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill Stillwell

FATHER 13. NAME W. E. Carter Sr 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER 15. MAIDEN NAME D. K. 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D. K.

17. INFORMANT (ADDRESS) Berta Strickland Brookfield, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mudville DATE Aug - 9 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hill Funeral Chapel Brookfield, Mo

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 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? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) D. H. Hanson D. O.  
Mudville Mo. M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. A. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

RECEIVED

District Health Officer No. 10

District File Number 10-38-141

Date Filed 9-15-38

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

*J. W. Blacklock*

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed

*J. W. Blacklock*

Licensed Embalmer No. 2246

P. O. Address Brookfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

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Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 503  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4306 Registered No. \_\_\_\_\_  
 (c) City meadville (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

William E. Carter  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF maitha E Carter  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 5 1865  
 7. AGE YEARS 73 MONTHS 7 DAYS 2 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Veterinary  
 9. Industry or business in which work was done, as 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) Stallwell (STATE OR COUNTRY) Illinois

FATHER 13. NAME W. E. Carter

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Verta Stappland  
meadville - mo

18. BURIAL, CREMATION, OR REMOVAL PLACE meadville DATE Aug 9 1938

19. FUNERAL DIRECTOR (ADDRESS) Full-Timer Funeral Home  
meadville - mo

20. FILED Aug 7 1938 W. E. Carter  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 7 1938

22. I HEREBY CERTIFY, That I attended deceased from May 15 1938 to Aug 7 1938  
 I last saw him alive on Aug 7 1938 Death is said to have occurred on the date stated above, at 3 A.M.  
 The principal cause of death and related causes of importance were as follows:

myocardial pectoris  
respiratory  
emphysema  
Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

(Signed) S. N. Harrison M. D.  
 (Address) meadville mo

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

