

REC'D MAR 20 1939

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

7516

Do not use this space.

1. PLACE OF DEATH

(a) County Pike Registration District No. 687

(b) Township Prairieville Primary Registration District No. 5-15 Registered No. _____

(c) City _____ (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 Zuma Carter

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

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) Aug 22nd 1863

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

75 5 23

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Keeping

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) (STATE OR COUNTRY) Eolia Mo

FATHER 13. NAME John Carter

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

MOTHER 15. MAIDEN NAME Sallie Calvert

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

17. INFORMANT (ADDRESS) Carrle Morris
Eolia, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Episcopal Cemetery DATE Feb. 16, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hoach & Hdwie Co.
Eolia - Mo.

20. FILED Feb. 16th 1939 - B. M. Hoach
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 15th 1939

22. I HEREBY CERTIFY THAT I attended deceased from _____, 1939, to Feb 15th 1939, 1939

I last saw her alive on Feb. 14th 1939. Death is said to have occurred on the date stated above, at 4 A. M.

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

Chronic Catarrh of bowels
Broken Hip

Date of onset Jan 15

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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) C. H. B. Ann M. D.
Paynesville, Mo.
 618 (Address)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

75-16
Do not use this space.

1. PLACE OF DEATH

(a) County Pike Registration District No. 687
(b) Township Prarieville Primary Registration District No. 5915
(c) City..... (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

(a) Residence, No. Zuma Carter 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 7 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.
75 0 23

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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) (STATE OR COUNTRY)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-15-1937

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

Chronic Catarrh of bowels
Broken Hip due to fall on street in Peoria - mo. - 8 (one on other contributory causes of importance)
Impacted fracture

Name of operation..... Date of.....

What test confirmed diagnosis? X-ray 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 P. L. Barkhead, M. D.
(Signed) Prarieville mo.
(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 PAID IN FULL BY LAW. PAYMENT MUST BE MADE IN ADVANCE.

SUPPLEMENTARY

