

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

Do not use this space.

32075

1. PLACE OF DEATH
 County Cape Girardeau Registration District No. 125
 Township St. Francis Hospital Primary Registration District No. 3009 File No. 324
 City St. Francis Hospital (No. 324) Registered No. 324 Ward St. Francis Hospital

2. FULL NAME Baby Carter
 (a) Residence, No. St. Francis Hospital St. St. Francis Hospital Ward St. Francis Hospital
 (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>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>9-18-39</u>			
7. AGE	YEARS	MONTHS	DAYS
	<u>0</u>	<u>0</u>	<u>0</u>
If LESS than 1 day, hrs. or min.			
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	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Cape Girardeau Mo.</u>		
	13. NAME <u>Carl Carter</u>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Malden Mo.</u>		
MOTHER	15. MAIDEN NAME <u>Lorana Miller</u>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Malden Mo.</u>		
17. INFORMANT (ADDRESS) <u>Carl Carter</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Francis Hospital</u> DATE <u>9-19-39</u>			
19. UNDERTAKER (ADDRESS) <u>St. Francis Hospital</u>			
20. FILED <u>9-18-39 9:30 a.m. St. Francis Hospital</u> Registrar.			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-18-1939

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 9:30 A.M.

The principal cause of death and related causes of importance were as follows:
Premature parturition
4 m. gestation
Spontaneous

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) D. B. Schall, M. D.
 (Address) Cape Girardeau Mo.

