

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 I 19311

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35669

State File No. _____

Registration District No. 111 Primary Registration District No. 5160 Registrar's No. _____

1. PLACE OF DEATH: Callaway Co. Mo
 (a) County Callaway Co. Mo
 (b) City or town STEPHENS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: No 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution No (Specify whether years, months or days)
 In this community 10 Months

2. USUAL RESIDENCE OF DECEASED: 1
 (a) State Mo (b) County Boone
 (c) City or town Columbia Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Around Columbia - "Rural"
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. No years.

8. (a) PRINT FULL NAME Charles Edward CARTER
 8. (b) If veteran, name war No 3. (c) Social Security No. 487-18-9000

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 22 year 1939 hour 1 minute 15 M.
 21. I hereby certify that I attended the deceased from Oct 22 1939 to Oct 22 1939
 that I last saw him alive on 10-22-39 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mary Ethel Carter 6. (c) Age of husband or wife if alive 46 years
 7. Birth date of deceased July 27 1879
 (Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration 1 hr.

8. AGE: Years 60 Months 2 Days 25 If less than one day hr. _____ min. _____

Due to _____
 Due to _____

9. Birthplace Randolph Co. MO
 (City, town, or county) (State or foreign country)

Other conditions dy (Include pregnancy within 3 months of death)

10. Usual occupation W. P. A.

Major findings: not known
 Of operations _____
 Of autopsy No

11. Industry or business W. P. A.

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

12. Name Colby Winford Carter
 13. Birthplace Virginia
 (City, town, or county) (State or foreign country)

14. Maiden name Angeline Marshall
 15. Birthplace Dont Know
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Mary Carter
 (b) Address Stephens, Mo

17. (a) Burial (b) Date thereof Oct 24 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Providence

18. (a) Signature of funeral director R. Overstreet
 (b) Address Columbia Mo

19. (a) Oct 24, 1939 (b) B. H. Stephens
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature B. H. Stephens (M. D. or other) _____
 Address Columbia Mo Date signed _____

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

Signed *Lynard H. Spaulding*
Licensed Embalmer No. *4013*
P. O. Address *Columbia, 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.