

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.

Registration District No. 625

Primary Registration District No. 3031

Registrar's No. 167

1. PLACE OF DEATH:  
 (a) County Nodaway  
 (b) City or town Maryville  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 25 years (Month) (Day) (Year)

3. (a) PRINT FULL NAME French Carter 636  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Susan C 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased July 14 1850  
 (Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Illinois  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name Joseph Carter  
 18. Birthplace Ohio  
 (City, town, or county) (State or foreign country)

14. Maiden name Anna Wilson  
 15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Carl Akers  
 (b) Address Stewartsville Mo.

17. (a) Wiley Mo (b) Date thereof Nov. 21-39  
 (Burial, cremation, or other) (Month) (Day) (Year)  
 (c) Place: burial or cremation Wiley Mo

18. (a) Signature of funeral director Clay M Price  
 (b) Address Maryville Mo

19. (a) 11-24-39 (b) Wm E. Clardy  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Nodaway  
 (c) City or town Maryville  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 410 S. Buchanan  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19  
 year 1939 hour one minute Ten A. M.

21. I hereby certify that I attended the deceased from Nov. 4, 1939, to Nov. 19, 1939;  
 that I last saw him alive on Nov. 18, 1939,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Impacted fracture Rt. neck of femur Duration 16 days.

Due to Fall in home

Due to \_\_\_\_\_

Other conditions Cardio-vascular-renal disease leukemia  
 (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) Accident  
 (b) Date of occurrence Nov. 3, 1939

(c) Where did injury occur? Maryville Nodaway Mo.  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
In home

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. H. Landfather (M. D. or other) \_\_\_\_\_  
 Address Maryville Mo. Date signed 11-21-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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**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, or by.....

*Clayton M. Price*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Clayton M. Price*

Licensed Embalmer No..... *1822*

P. O. Address..... *Wayville, W.*

**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.**