

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10947

State File No. _____

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 233

39
3
6

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

1. PLACE OF DEATH GREENE

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether In this community _____ years, months or days)

3. (a) PRINT FULL NAME Charles Randolph Carr

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 _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 18 1939
(Month) (Day) (Year)

8. AGE: Years ✓ Months 7 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Francis W. Carr

13. Birthplace Liberty Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Kaiser

15. Birthplace Jefferson City Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Francis W. Carr

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof March 6 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fulton, Missouri

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo. 290

19. (a) 3/5/40 (b) Chas. A. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. 1111 Roanoke
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4
year 1940 hour 2 minute p. M.

21. I hereby certify that I attended the deceased from 2-28-40
_____ 19 _____ to 3-4-40 19 _____
that I last saw him alive on 3-4-40 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death: acute laryngitis & obstruction (now diphtheritic) 2 days

Due to: acute Upper Respiratory Infection 5 days

Due to: _____

Other conditions: _____
(Include pregnancy within 8 months of death)

Major findings: _____

Of operations: _____

Of autopsy: as above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 For. J. Schwartz (M. D. or other) _____
Address Med. Bldg. Springfield Date signed 3-4-40

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.....

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

working under my personal supervision.

Signed

L. Doolin Gorman

Licensed Embalmer No. *3177*

P. O. Address *Springfield 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.