

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

14401
Do not use this space.

1. PLACE OF DEATH

(a) County BUCHANAN Registration District No. 85
 (b) Township _____ Primary Registration District No. 1001 Registered No. 504
 (c) City ST. JOSEPH (d) Street No. ST. JOSEPH HOSPITAL 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. / da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME JAMES ASHFORD CARTER

(a) Residence, No. Gallatin, Mo. St. Gallatin, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Minnie Carter

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July-26-1866

7. AGE YEARS 73 MONTHS 9 DAYS 7 IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
 10. Date deceased last worked at this occupation (month and year) Retired 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) Gallatin (STATE OR COUNTRY) Missouri

FATHER 13. NAME John Wesley Carter

14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Ohio

MOTHER 15. MAIDEN NAME Malissa Gritten

16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Mrs. Homer White
Gallatin, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Gallatin, Mo. DATE 5/5 1940

19. FUNERAL DIRECTOR (NAME) Hope Turner & Wood (ADDRESS) Gallatin, Mo.

20. FILED 5/4/40 1940 H. J. Kelleher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May-3-1940

22. I HEREBY CERTIFY, That I attended deceased from 5/3, 1940, to 5-3, 1940

I last saw him alive on 5-3, 1940 Death is said to have occurred on the date stated above, at 5:45 p.m.
 The principal cause of death and related causes of importance were as follows:

Hypertension & Pneumonia
Urinary Obstruction
uremia

Date of onset 15 days ago

Other contributory causes of importance: 12/1

Name of operation None Date of _____

What test confirmed diagnosis? Chem 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 _____

Was disease or injury in any way related to occupation of deceased? no

(Signed) Chas. Greenberg, M. D.
 (Address) St. Joseph, Mo.

N. B.—Every item of information should be carefully supplied. ACE 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.

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. O. Richesson*

Licensed Embalmer No. *3392*

P. O. Address *Gallatin, Md.*

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.