

FILE MAY 2 1940

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

14984

Do not use this space.

1. PLACE OF DEATH *Harrison*  
 (a) County *Harrison* Registration District No. *337*  
 (b) Township *Eagleville* Primary Registration District No. *4200* Registered No. *6*  
 (c) City *Eagleville* (d) Street No. \_\_\_\_\_ (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 *24* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *MARIA JANE CARTER*  
 (a) Residence, No. *Eagleville* St.  (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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *widowed*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *W H Carter*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 19, 1853*  
 7. AGE YEARS *87* MONTHS \_\_\_\_\_ DAYS *11* IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Housewife*  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) *1930* 11. Total time (years) spent in this occupation *57*  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Brooklyn Mo*  
 FATHER 13. NAME *Dennis Bigger*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unk Va*  
 MOTHER 15. MAIDEN NAME *Susan Woodward*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unk Va*  
 17. INFORMANT (ADDRESS) *John E Cook Eagleville Mo*  
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Murkey* *Apr 1 40*  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Robertway J. Moore Eagleville Mo*  
 20. FILED *April 6 1940 Marie Smith* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 30 1940*  
 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 *5:30 am*.  
 The principal cause of death and related causes of importance were as follows:  
*Death without medical attendance, from natural causes probably due to infirmities of age.* Date of onset \_\_\_\_\_  
 Other contributory causes of importance: *162*  
 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. *Signed*  
 Manner of injury *X Florida Baker*  
 Nature of injury *X Adip. Cor.*  
 24. Was disease or injury in any way related to occupation of deceased? *S*  
 If so, specify *X H. H. Bunting*  
 (Signed) *X Mary E. Eganberger* M.D.  
 904 (Address) *all of Eagleville Mo*  
*Marie Smith*  
*Eagleville Mo*

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.

1 X16803

RECEIVED

District Health Officer No. 11,

District File Number

Date Filed

MAY 6

1948

540-637

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **14984**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **837**

Primary Registration District No. **4200**

Registrar's No. \_\_\_\_\_

*RM*

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

1. PLACE OF DEATH:

(a) County Harrison  
(b) City or town Eagleville  
(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 \_\_\_\_\_  
years, months or days)

3. (a) PRIME FULL NAME Maria Jane Carter

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 87 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Oct-4-1940 (b) Maria Smith (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 30 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

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

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) (Means of injury)

23. Signature Maria Smith (M. D. or other) \_\_\_\_\_

Address Eagleville, Ma Date signed 10-7-40

SUPPLEMENTARY

S-14984