

MAY 8 1940
Registration District No. 604

Primary Registration District No. 175

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Marion
(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 years, months or days) 9 Months

3. (a) PRINT FULL NAME WILLIE E. Carter 63

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

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

6. (b) Name of husband or wife Beatrice Carter
6. (c) Age of husband or wife if alive 95 years

7. Birth date of deceased April 10th 1890
(Month) (Day) (Year)

8. AGE: Years 50 Months X Days X
If less than one day hr. min.

9. Birthplace Don't know
(City, town, or county) (State or foreign country)

10. Usual occupation Factory labour

11. Industry or business Farmer

12. Name Unknown

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's own signature Rachler

(b) Address Marion Mo

17. (a) (Burial, cremation, or removal) (b) Date thereof April 11 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Madison Cemetery

18. (a) Signature of funeral director

(b) Address Watkins Fun. Service, Dexter Mo

19. (a) 6/13/1940 (b) Wm. H. O'Bannon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County New Madrid
(c) City or town Marion, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Rural 8 miles S. west
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 10 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from Apr 9, 1940, to Apr 9, 1940; that I last saw him alive on Apr 9, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 9 days

Due to ?

Due to ?

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None made

Of autopsy None made

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?

5 While at work? (Specify type of place) (b) Means of injury

23. Signature Raymond C. Conrad (M. D. or other) M. D.

Address Princeton, Mo Date signed 4-11-40

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 X1951

RECEIVED

District Health Officer No. _____

District File Number 540/98

Date Filed 5/3/40

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.....

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. 15-384

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 604

Primary Registration District No. 3798

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. New Madrid

(b) City. New Madrid T.P.
(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. 3 months
(Specify whether years, months or days)

In this community. 3 months

3. (a) PRINT FULL NAME Willie C. Carter

3. (b) If veteran, name war.

3. (c) Social Security No. ---

4. Sex. m

5. Color or race. Col

6. (a) Single, widowed, married, divorced. married

6. (b) Name of husband or wife. Beatrice Carter

6. (c) Age of husband, or wife, if alive. --- years

7. Birth date of deceased. Apr 10 1890
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>50</u>			hr. min.

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

10. Usual occupation. Farm laborer

11. Industry or business. Farming

12. Name. Willie C. Carter

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. R. C. Cheers

(b) Address. Marston Mo

17. (a) (b) Date thereof. Apr 11/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. macon cem

18. (a) Signature of funeral director. Watkins Funeral Service

(b) Address. Marston Mo

19. (a) 6/13/1940 (b) Wm O. Bannan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo (b) County. New Madrid

(c) City or town. Marston Mo
(If outside city or town limits write "RURAL")

(d) Street. Rural 8 mi S west.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month. 10 day. April
year. 1940 hour. minute. M.

21. I hereby certify that I attended the deceased from Apr 9 1940, to Apr 9 1940, that I last saw him alive on Apr 9 1940, and that death occurred on the date and hour stated above.

Immediate cause of death. Lobar Pneumonia

Due to.

Due to.

Other conditions. none
(include pregnancy within 3 months of death)

Major findings:

Of operations. none

Of autopsy.

Duration 9 days

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. Raymond C. Conard (M.D. or other)

Address. Pattingville Mo Date signed.

